Issue without Boundaries: HIV/AIDS in Southeast Asia

Jönsson, Kristina

2006

Issue without Boundaries:
HIV/AIDS in Southeast Asia

Kristina Jönsson

Working Paper No 19
2006

Centre for East and South-East Asian Studies
Lund University, Sweden

www.ace.lu.se

* Research fellow at the Centre for East and South-East Asian Studies, Lund University.
Email: Kristina.Jonsson@ace.lu.se

WORKING PAPERS IN CONTEMPORARY ASIAN STUDIES

General editor: Professor Roger Greatrex
Assistant editor: Nina Brand

Publications in this series:

1. Is the world Ready for a Coherent ASEAN+3? / Cesar de Prado Yepes / ISBN 91-975093-0-2
2. Renegotiating Gender and Power: Women's Organizations and Networks in Politics – The China Women Mayors' Association / Qi Wang / ISBN 91-975093-1-0
3. Re-evaluating Preventive Diplomacy in Southeast Asia / J. Michael Tivayanond / ISBN 91-975093-2-9
4. The Role of Law in Contemporary Indonesia / Mason C. Hoadley / ISBN 91-975093-3-7
5. Closing the Digital Divide: Southeast Asia's Path towards a Knowledge Society / Hans-Dieter Evers and Solvay Gerke / ISBN 91-975093-4-5
6. De-colonising Indonesian Historiography / Henk Schulte Nordholt / ISBN 91-975093-5-3
7. Path Dependence, Change, Creativity and Japan's Competitiveness / Cornelia Storz / ISBN 91-975093-6-1
8. China Regaining Position as Source of Learning / Jon Sigurdson / ISBN 91-975093-7-X
9. Prospering on Crime: Money Laundering and Financial Crises / Guilhem Fabre / ISBN 91-975093-8-8
10. Implementing anticorruption in the PRC – Patterns of selectivity / Flora Sapio / ISBN 91-975093-9-6
11. Shaping the Future of Asia – Chiang Kai-shek, Nehru and China-India Relations During the Second World War Period / Guido Samarani / ISBN 91-975726-0-8
12. The Consumer Citizen in Contemporary China / Beverley Hooper / ISBN 91-975726-1-6
13. Defining Southeast Asia and the Crisis in Area Studies: Personal Reflections on a Region / Victor T. King / ISBN 91-975726-2-4
14. Women in Politics in Thailand / Kazuki Iwanaga / ISBN 91-975726-3-2
15. The Return of Piracy: Decolonization and International Relations in a Maritime Border Region (the Sulu Sea), 1959-63 / Stefan Eklöf / ISBN 91-975726-4-0
16. Youth and the State in Contemporary Socialist Vietnam / Phuong An Nguyen / ISBN 91-975726-5-9
17. In the Ancestors' Shadow: Cultural Heritage Contestations in Chinese Villages / Marina Svensson / ISBN 91-975726-6-7
18. Policies and politics underlying the path for universal access to treatment against AIDS in Cambodia / Frédéric Bourdier / ISBN 91-975726-7-5
19. Issue without Boundaries: HIV/AIDS in Southeast Asia / Kristina Jönsson / ISBN 91-975726-8-3

ISSN: 1652-4128
ISBN: ISBN 91-975726-8-3
Layout: Petra Francke, Lund University, Information Office
Printed in Sweden by Lund University, Media-Tryck, 2006

Abstract

This paper is a first attempt to analyse the relationship between global, national and local strategies to combat HIV/AIDS in the light of the increasing globalisation. What kinds of strategies are being used to fight HIV/AIDS? What makes certain policies more successful than others? Has the epidemic given rise to new actors and collaboration patterns nationally and internationally? What is the state capacity to deal with the HIV/AIDS issue? In other words, policies and the changing context of policymaking in the field of HIV/AIDS are of special interest in the analysis, which in turn raises questions about changing health governance and the role of the state. The paper focuses on HIV/AIDS in Southeast Asia, a region that includes countries with everything from relatively high to low rates of HIV infected, and from successful HIV/AIDS policies to a lack of action. Because of their geographical position and their different exposure to the HIV/AIDS epidemic, Thailand Cambodia, Burma/Myanmar, Vietnam and Laos are at the core of the analysis making it possible to draw on a wide range of experiences in the field of HIV/AIDS. The study is explorative in character both theoretically and empirically. The theoretical framework is based on literature dealing with policymaking, governance issues, globalisation and international relations, while the empirical material come from a wide range of sources such as "personal communication", policy documents, newspapers and academic publications. The preliminary conclusions indicate that the strategies to combat the HIV/AIDS epidemic vary according to the stage of the epidemic, together with how HIV/AIDS is framed and perceived. At the same time there is a trend of streamlining the strategies in line with global initiatives like the Millennium Development Goals and UNAIDS guidelines. Although some strategies and policies are perceived as more successful than others, success is a relative concept depending on context and structural factors such as political, bureaucratic and health care systems as well as on societal changes. There are an increasing number of actors in the field of HIV/AIDS, including public-private partnerships, which make new demands on the state. Nevertheless, the role of the state does not appear to diminish, but the changing policymaking context rather put increasing demands on coordination and new types of governance. This, in turn, warrants further research.

Keywords: HIV/AIDS, Southeast Asia, Thailand, Burma/Myanmar, Cambodia, Vietnam, Laos, policymaking, globalisation, governance.

Contents

PART ONE: HIV/AIDS in Southeast Asia 1
Introduction 1
Why HIV/AIDS and policymaking in Southeast Asia? 2
Relation to previous research 4
A comment on methodology 5

PART TWO: The epidemic and policy responses 7
The policy process 7
Thailand 9
Burma/Myanmar 11
Cambodia 13
Vietnam 15
Laos 17
What makes some strategies more successful than others? 19
Scope and type 19
Framing and perceptions 19
Nothing is static 21
To sum up 23
The policy environment 23
Political system 24
Bureaucratic system 26
Health care system 28
Policymaking in a globalising world 30

PART THREE: New actors and the role of the state 31
New actors and collaboration patterns 32
The role of the state 35
Why on the political agenda now? 38

PART FOUR: Concluding remarks 40
References 42

Country	*Population*	*GDP/capita*	*Type of government*	*Life expectancy*
Thailand	63.8 million	2291 USD	Parliamentary Democracy, Constitutional Monarchy	71 years
Burma/ Myanmar	50.1 million	179 USD	Military	57 years
Cambodia	13.1 million	310 USD	Parliamentary Democracy, Constitutional Monarchy	57 years
Vietnam	81.5 million	481 USD	One party state, socialist republic	72 years
Laos	5.8 million	362 USD	One party state, socialist republic	54 years

Sources: www.freedomhous.org (2005); www.aseansec.org/macroeconomic/aq_gdp22.htm (2006); Regional Outlook Southeast Asia 2006-2007. Institute for Southeast Asian Studies, Singapore, 2006.

Abbreviations

ADB	Asian Development Bank
AFC	Asian Financial Crisis
ARV	Anti-retroviral drugs
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Government's Overseas Aid Program
CDC-GAP	Center for Disease Control and Prevention's-Global AIDS Programme
DFID	Department for International Development (UK)
ECPAT	End Child Prostitution, Child Pornography and Trafficking in Child for Sexual Purposes
EU	European Union
FHAM	The Fund for HIV/AIDS in Myanmar
FHI	Family Health International
FPP	Family Planning Programmes
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDU	Injecting Drug Users (or intravenous drug users)
IEC	Information, Education and Communication
JICA	Japan International Cooperation Agency
KHANA	Khmer HIV/AIDS NGO Alliance
MDG	Millennium Development Goals
MdM	Médecins du Monde
MSF	Médecins Sans Frontières/Doctors Without Borders
NAA	National AIDS Authority (Cambodia)
NCA	Norwegian Church Aid
NCADP	National Committee for AIDS, Drugs and Prostitution (Vietnam)
NCCA	National Committee for the Control of AIDS (Laos)
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NSP	National Strategic Plan (Cambodia)
PEPFAR	President Bush's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV/AIDS
PSF	Pharmacies Sans Frontier
PSI	Population Service International
STD/STI	Sexually Transmitted Diseases/Sexually Transmitted Infections

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations Office on Drugs and Crime
UNDP	United Nations Development Fund
UNICEF	United Nations Children's Fund
UNTAC	United Nations Transitional Authority in Cambodia
URC	United Reformed Church
USAID	United States Agency for International Development
WB	World Bank

PART ONE: HIV/AIDS in Southeast Asia

Introduction

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) has been described as one of the worst pandemics of modern time. Since its inception around 20 million have died from AIDS. Globally approximately 40 million men, women and children are living with HIV/AIDS, affecting an even greater number due to inability to work and to support family members (www.unaids.org). The costs are high, both in economic terms and in terms of social stigma and discrimination. Also, the great losses of skills and knowledge have long-term effects on the whole society. As the HIV/AIDS epidemic has increased in scope, the perception of HIV/AIDS has changed. From being treated as a medical problem needing medical solutions, it is now widely acknowledged that a much broader approach is needed. Social, economic, cultural and political issues are part of the problem as well and hence also part of the solution. Moreover, HIV/AIDS is spreading across borders making it a worldwide concern. Until recently Sub-Saharan Africa has been in focus. Yet, lately Eastern Europe, the former Soviet Union and Asia are perceived as new "hot zones" due to the rapid increase of HIV infections in those regions (see e.g. Goodwin *et al.* 2003; Webster 2003). However, there is a great variety in how to deal with HIV/AIDS regarding approaches and strategies—some more successful than others. Global initiatives are interacting with national and local ones adding to the complexity. Consequently there is an urgent need to learn more about both the disease and the (policy) processes associated with HIV/AIDS in order to meet the challenges of the epidemic.

The purpose of this paper is to analyse the relationship between global, national and local strategies to combat HIV/AIDS in the light of the increasing globalisation. What kinds of strategies are being used to fight HIV/AIDS? What makes certain policies more successful than others? Has the epidemic given rise to new actors and collaboration patterns nationally and internationally? What is the state capacity to deal with the HIV/AIDS issue? In other words, policies and the changing context of policymaking in the field of HIV/AIDS are of special interest in the analysis, which in turn raises questions about changing (health) governance and the role of the state. The paper focuses on HIV/AIDS in Southeast Asia, a region that includes countries with the full spectrum of relatively high to low rates of HIV infected, and from successful HIV/AIDS policies to a lack of action. Because

of their geographical positions and their different exposure to the HIV/AIDS epidemic, Thailand, Burma/Myanmar,[1] Cambodia, Vietnam and Laos will be at the core of the analysis, making it possible to draw on a wide range of experiences in the field of HIV/AIDS. The paper is a first attempt to discuss the questions above and consequently it is by no means comprehensive. The idea is rather to get an overview of the HIV/AIDS situation in the region, and to create a tentative theoretical framework that later can be refined and used to analyse the problem area more thoroughly. The paper is divided into four parts: The introductory part gives the background to the study and research problem. The second part focuses on the epidemic in Southeast Asia together with policy responses in the five selected countries. "Successful policies" are problematised by introducing structural factors. The third part initiates a discussion about governance issues in the field of HIV/AIDS. The fourth part consists of concluding remarks and suggestions for further research.

Why HIV/AIDS and policymaking in Southeast Asia?

Arguably globalisation, or processes associated with globalisation, has created social conditions that have influenced the transmission of, incidence of, and vulnerability to the disease among individuals and groups (Lee and Dodgson 2000). For example, the spread of HIV/AIDS has been facilitated by changes in the spatial dimension of human relations through migration and migrant labours, tourism, displacement and occupying military forces (Lee and Zwi 2003: 18). In addition, the reduction of public health expenditure, as part of the neo-liberal discourse of the World Bank and the IMF, has rendered many governments less prepared to handle the HIV/AIDS epidemic (see e.g. Brugha and Zwi 2002: 65), affecting especially the poor with rising health inequalities as a result. Poverty, in turn, increases risk behaviour such as sex work. As the majority of the people estimated to be HIV infected live in low-income countries (Lee and Zwi 2003: 20), the problem will most likely become even more precarious in the future.

However, it is the lack of appropriate policymaking to meet the effects of globalisation that is the real problem. At the international level HIV/AIDS has been on the agenda for some time. Today it is one of the United Nations' Millennium Development Goals (MDG), and a large number of NGO are involved in the field together with many bilateral and multilateral

[1] The official names are the Kingdom of Thailand, Myanmar, the Kingdom of Cambodia, the Socialist Republic of Vietnam and Lao People's Democratic republic (Lao PDR). Burma was renamed Myanmar by the military junta in 1989, but the decision has been questioned by civilians as well as parts of the international community (see e.g. Schairer-Vertannes 2001).

organisations and agencies. In 2002 the Global fund to fight HIV/AIDS, Tuberculosis and Malaria was founded bringing together governments, civil society, the private sector and the affected communities in a new approach to international health financing (Poore 2004; Piot and Seck 2002; www.unaids.org). HIV/AIDS is also increasingly being viewed as a security threat opening up for new types of interventions. The argument is that there is a "growing acceptance that national sovereignty cannot be relied upon to respond to problems of global significance" (Altman 2003: 35) referring to the failure to provide public and possibly also regional order. At the same time pharmaceutical companies, patent rights, trade regimes, and issues like Trade-related Intellectual Property Rights (TRIPS) complicate the issue (Kermani and Bonacossa 2003: 337; Patterson and London 2002) by confronting economic interests and public health. At the national level Thailand is being described as a success story in combating HIV/AIDS (Ainsworth *et al.* 2003), together with Uganda, Senegal and Brazil (Moran 2004: 10), while China, for example, still receives criticism because of its inefficient HIV/AIDS policy driving HIV/AIDS victims underground (see e.g. *Far Eastern Economic Review* Jan. 9, 2003; Altman 2003: 43)—even if there has been a shift of AIDS policy in China the last few years towards increasing funding and political commitment (Zhang 2004).

Part of the success story can be ascribed to the successful fight against pharmaceutical companies and the high costs of antiretroviral drugs indicating a clear link between international and domestic policymaking (see e.g. Shadlen 2004). One can thus speak of new forms of governance where the role of the state is being challenged and where various organisations and social movements are becoming more important.

A study of Southeast Asia is interesting for many reasons. Thailand, Burma/Myanmar, Cambodia, Vietnam and Laos share many characteristics concerning socio-economic factors, even though Thailand is more developed economically than the other four countries.[2] For example, to various degrees they all struggle with poverty, eroding health care systems, prostitution, human trafficking, and drug use—factors contributing to the increasing risk of HIV/AIDS. At the same time as their experiences in the field of HIV/AIDS differs, as will be discussed more in detail later. It is also believed that the road network project connecting China, Laos, Vietnam, Thailand and eventually Burma/Myanmar will facilitate the spread of HIV/AIDS (Feingold 2000: 91).

[2] In 2004 the GDP/capita in Thailand was 2291 USD, in Vietnam 481 USD, in Laos 362 USD, in Cambodia 310 USD and in Burma/Myanmar 179 USD (http://www.aseansec.org/macroeconomic/aq-_gdp22.htm).

Thailand, Burma/Myanmar and Cambodia are the three countries with the highest rates of HIV/AIDS in Southeast Asia, and in Thailand AIDS has even become the leading cause of death among young people. However, both Thailand and Cambodia have been successful in their fight against HIV/AIDS, much because of strong political commitment, involvement of civil society and a wide range of preventive activities. At the same time Burma/Myanmar stands on the brink of what may be one of the most serious epidemics in Asia with continuously rising HIV infection rates. The continued international disengagement adds to the problem together with ethnic conflicts.

The HIV prevalence rates in Vietnam and Laos have remained relatively low. However, with high rates in the neighbouring countries together with increasing trade-related and tourism-related population mobility both within and across borders, the vulnerability of Vietnam and Laos is obvious (www.unaids.org). Also, Thailand's recent war against drugs has forced HIV/AIDS infected underground, and migrant workers from Cambodia and Burma/Myanmar working in non-registered Thai brothels will hardly be interested in preventive measures, if they fear they will be deported when they get in contact with public health workers (Ainsworth *et al.* 2003: 28).

Thus, the relation between local/national and regional/global policymaking is important, something which supports a broad perspective in the study of HIV/AIDS. The fact that the five countries have different political systems[3] and different kinds of relations with the international community and civil society (including NGOs) makes a comparison even more interesting.

Relation to previous research

Much research has been devoted to HIV/AIDS as well as to Southeast Asia and globalisation. However, the combination of the three is less common, especially from a political perspective. Lee and Zwi (2003: 14) argue that policymaking on AIDS has been biased towards biomedical and neo-liberal discourses excluding other perspectives. Global health, for example, has until now received relatively little attention within International Relations with a few exceptions (e.g. Lee 2002; Lee and Zwi 2003; Gordenker *et al.* 1995; Söderholm 1997). Medicine and social science used to focus at national and sub-national level contributing to the knowledge of the transmission

[3] Thailand is a parliamentary democracy, so is Cambodia which is practising a kind of "electoral authoritarian" rule, Laos and Vietnam are authoritarian one-party (socialist) states, and Burma/Myanmar has a repressive military regime.

mechanisms of HIV within certain groups, historical and cultural factors contributing to the HIV transmission, and the economic impact of AIDS on health systems and labour markets. In recent years analyses have included also gender issues, human rights, the impact of preventions strategies and the cost of treating HIV/AIDS (Lee and Zwi 2003; Patterson and London 2002).

HIV/AIDS in relation to public policy and administration has begun to receive attention highlighting political commitment, power relations between different domestic and international actors and the interplay between political, social and economic factors (see Gilbert and Gilbert 2004; Moran 2004; Willan 2004; Putzel 2004; Parkhurts and Lush 2004). Framing is another issue of political importance that is increasingly being stressed (see e.g. Sell and Prakash 2004 who discuss the contest between business and NGOs in Trade-related Intellectual Property Rights). Thailand is fairly well researched concerning HIV/AIDS, but relatively little is written about the HIV/AIDS situation in Burma/Myanmar, Cambodia, Vietnam and Laos. HIV/AIDS policy studies with a governance perspective are so far not common either (Jones 2005: 421), even if HIV/AIDS every now and then is used as a case in discussions about global governance (see e.g. Poku 2002).

A comment on methodology

This paper is a first attempt to develop a suitable theoretical framework and to test the research questions. No proper fieldwork has been conducted yet, even if two shorter trips have been carried out in order to establish research contacts and to get an overview of the HIV/AIDS situation in the countries: one to Vietnam, Laos, Cambodia and Thailand in March 2005 and one to Laos, Cambodia and Thailand in January 2006. Consequently the discussions I had with the around 20 key informants I met—representing international agencies, non-governmental organisations and academia—had the character of "personal communication" rather than formal interviews. The conclusions in this paper must therefore be viewed as preliminary.

My point of departure in this paper is that we live in a globalised, interconnected world. I also assume that the context of policymaking is changing together with the role of the state due to globalisation processes. However, in order to study the HIV/AIDS policies and strategies in the five selected countries and what impact the changing context has on the policymaking, I need to be more specific. In the next part of the paper I will try to answer the questions "What kinds of strategies are being used to fight HIV/AIDS?" and "What makes certain policies more successful than others". Here I will discuss in terms of policymaking and policy processes in relation

to the political environment. In the following part of the paper I intend to discuss the question "Has the epidemic given rise to new actors and collaboration patterns nationally and internationally" by focusing on the agenda-setting process and why HIV/AIDS has attracted so much attention lately. I will also elaborate on the question "What is the state capacity to deal with the HIV/AIDS issue?" in relation to the concepts of government and governance. Putting the different parts of the framework together, it hopefully will be possible to initiate a discussion about changes in health governance and the role of the state.

Thus, the theoretical framework is based on literature dealing with policymaking, governance, globalisation and international relations, while the empirical material come from a wide range of sources such as "personal communication", policy documents, news papers, and academic publications. The project is qualitative in character primarily using the case-study method with HIV/AIDS policymaking and governance in Southeast Asia at the centre (see e.g. Yin 1986). Still, within the case, comparisons will be conducted between the countries in the region where it is applicable (see Lijphart 1975). The countries are chosen because of their geographic proximity and because they represent different stages of the epidemic. Moreover, as the focus of this paper is the political aspects of the epidemic, these countries also provide suitable variations in political systems. I will not try to give a full explanation of why the HIV prevalence rate differs between the countries. For instance, from a biological perspective the modes of HIV/AIDS transmission can be sexual, from mother-to-child, and from blood. Social factors influencing the transmission pattern can, for example, be poverty, stigma and discrimination, gender inequalities, mobility/migration, conflicts, countries in transition, and incarceration (see e.g. UN 2005: 11-15). Although I to some extent discuss these issues in the paper, the main idea is to problematise the role of politics in the epidemic together with the state centred views that can be found in much of the policy literature—not to explain why the HIV/AIDS rate is higher in Thailand, Cambodia and Burma/Myanmar than in Vietnam and Laos.

PART TWO: The epidemic and policy responses

The policy process

How can we approach the complex issue of policymaking in the field of HIV/AIDS in an increasingly globalised world? As already noted, globalisation and processes associated with globalisation make people vulnerable to HIV/AIDS, but the interesting point here is that governments handle the situations differently depending on socio-economic, political and cultural factors. For example, the fact that Thailand is more economically developed and is more democratic than the other four countries matters, as much as the fact that Burma/Myanmar is governed by a repressive military regime, that Vietnam and Laos are governed within a one-party Marxist-Leninist framework, and Cambodia with a legacy of the Khmer Rouge and strong international presence. Culturally mainland Southeast Asia is a mosaic of different peoples and cultures,[4] and as much as these groups of people and cultures overlap between countries they also diverge along urban-rural divides. In addition, people's values and norms are constantly shifting together with changes in society, and some of these changes lead to behaviour that increase susceptibility for HIV infection (see e.g. Barnett and Whiteside 2002: 87), which in turn affects the impact of policies. Values are also important in the sense that they influence the choice of policies. For example, the latest Cambodian HIV/AIDS policy stress human rights, an issue that still is sensitive in many of the countries in the region. If this is a result of external influences or the democratic developments within the country can be debated, but regardless it indicates a shift towards the values prevalent at the global level since much of the aid is linked to rights-based approaches (see e.g. Patterson and London 2002). In other countries, such as Vietnam, the emphasis is still more on control and punitive measures to halt the epidemic representing a more authoritarian approach in policymaking (see e.g. Walters 2004: 77-78). An interesting question is of course how well the different policies implement, as a potential measure of success.

Considering the scope of this study, it is important to look at the policy process at different levels or layers—global, regional, national and local—as each level has its own constellation of actors with priorities of their own (see e.g Curtis 2004: 55). These interests may be both overlapping and divergent, with consequences for policymaking and the role of the state. To exemplify,

[4] In Thailand 75% belong to the major ethnic group, in Burma/Myanmar 68%, Cambodia 90%, Vietnam 85-90%, and Laos 60% (www.freedomhouse.org).

one could argue that the players on the global arena focus on one set of problems that have more broad societal consequences, such as the risk of collapsing societies due to the impact of HIV/AIDS, while a regional organisation such as Association of Southeast Asian Nations (ASEAN) focuses on migration and efforts to halt the spread of HIV/AIDS. A national policy may focus on what is perceived as the main problem in that specific country, which could be, for instance, lack of condoms among sex workers or care and support of HIV/AIDS infected. Thus, it is important to look at why certain policies are developed and adopted and how they are related geographically as well as between layers, in order to understand why some policies are perceived as more successful than others.

There are several theories about policymaking,[5] and most of them assume a democratic framework with pluralistic decision-making, feed-back mechanisms and possibilities for public scrutiny (see e.g. Walt 1994). In the case of HIV/AIDS and policymaking in Southeast Asia, the situation is very different since we are talking about policymaking in more or less authoritarian countries that are to various degrees dependent on international aid. While there are few alternatives, I will use the basic policymaking model where the policy process is divided into four phases: agenda-setting, policy formation (including decision-making), implementation and evaluation (i.e. feed-back). This model has rightly been criticised for being too simplistic by assuming that decisions are made in a rational way and that policymaking is a linear process—something that rarely happens in reality. Despite the criticism I think the model works to bring analytical order to complex processes (also see Hill and Hupe 2002:6; Howlett and Ramesh 2003; Walt 1994), and therefore I will use it as a point of departure in this paper.

Having said that, I will put special emphasis on the agenda-getting phase, as I am interested in how and why the policymaking changes in the field of HIV/AIDS. I will let the Kingdon model guide the discussion (Kingdon 1995). This model assumes that three streams—the problem, the policy and the political stream—must meet in order for policy changes to happen. The problem stream consists of a set of issues that the government, media, the public and in this case also the international community, find pressing; the policy stream involves the existing alternatives that are being discussed; and the political stream (or political opportunity structure) is to what extent the policy makers are prepared to accept the new ideas and alternatives. All three streams are hence necessary for a so-called window of opportunity to occur.

[5] When I talk about policymaking I refer to public policymaking and policies issued by the government if nothing else is stated. At the international level I refer to policies made by organisations with state/government memberships (e.g. ASEAN, UN, WB).

The window of opportunity is often caused by a special event such a crisis of some sort. In addition, a forum is needed where the streams can meet, for instance an international meeting or conference. It is also important that there are communicators who can spread and argue for the policy. These policy agents may be part of networks, epistemic communities (Haas 1992) or advocacy groups (Sabatier and Jenkins-Smith 1993). To exemplify, the Rockefeller Foundation held a meeting in 1994, which created a window of opportunity for HIV/AIDS research. In this meeting scientists, public health officials, NGO representatives and leaders from the pharmaceutical industry participated. The topic of the conferences was how to move forward with AIDS vaccination research. The interesting thing was that before the meeting support to research on AIDS vaccines was politically impossible, while after the meeting the International AIDS Vaccine Initiative was developed. Since then the issues of AIDS vaccines has been on the global agenda (Tepper 2004: 534). To put it in terms of Kingdon's model, there was a pressing problem (the HIV/AIDS epidemic), there was a solution that could be translated into policy (there was a possibility to find a vaccine if more money was to be spend on research), and the leaders realised they had to do something about the situation. The conference created a window of opportunity for action, and eventually ARV was included at the global policy agenda.

This model is useful when we want to explain why certain polices are adopted at a certain time (i.e. when the three streams meet). It is also useful when the policy situation is unclear and the outcome is unpredictable. However, it does not help to explain why they change more incrementally. Then the traditional policy cycle model may be a better analytical model. Hence, in order to understand policymaking in the field of HIV/AIDS in a rapidly changing world we must combine different models and theories, which I intend to do. In the following sections I will focus on the five countries and how they have handled the HIV/AIDS epidemic in order to identify different strategies and to discuss why some of them have been more successful than others.

Thailand

In this paper, Thailand will serve as a point of reference. The reason is that Thailand is widely cited as one of the few examples of a successful HIV/AIDS prevention strategy (see e.g. Ainsworth *et al.* 2003). Thailand is also one of the countries with the highest infection rates in the region (in 2005 1.5 percent out of a population of 60 million, see e.g. www.unaids.org). The success in Thailand has mainly been ascribed to political support together with help

from the civil society, which has enabled comprehensive programmes covering the whole society. Public policy has clearly made an impact as well (Ainsworth *et al.* 2003: 14).

The first case of HIV/AIDS was detected in September 1984 among gay men returning from abroad, but the first evidence of rapid spread was not detected until 1988. Prior to 1989 the government policy followed a "standard" public health approach, which means that AIDS cases were reported through the medical system. This, however, turned out to lead to underreporting (Ainsworth *et al.* 2003: 14). When it became evident that HIV had spread to the general population, especially in the North, the public perception of the epidemic changed. At first the danger was downplayed because economic prosperity was on the top of the agenda and of possible negative impacts in tourism, but the fact that income from tourism was at risk pushed for radical measures (see Barnett and Whiteside 2002: 334).

Thailand was the first country in Asia to set up a National Advisory Committee on AIDS in 1987, and a national AIDS control programme, with a medium-term plan for 1989-1991 (UNDP 2004: 8). In 1991-1992, on the advice of Mr Mechai Viravidya, head of family planning and AIDS-NGO and also called "condom king of Thailand", or Mr Condom (Lee-Nah Hsu 2004: 13), AIDS prevention and control became a national priority under the responsibility of the Office of the Prime Minister with a multi-sectoral "National AIDS Prevention and Control Committee" chaired by the Prime Minister Anand Panyarachun (Ainsworth *et al.* 2003: 15). A massive public information campaign followed, peer education programmes were introduced and very efficient 100% condom programme was implemented among sex workers—despite that prostitution was, and still is, illegal. Compliance of the 100% condom programme was monitored through a wide network of Sexually Transmitted Diseases (STD) treatment clinics. At the same time mandatory reporting of names and addresses was abolished. Thus, the government was very pragmatic in its approach.

According to Ainsworth *et al.* (2003: 18-19) part of Thailand's success can be attributed to already existing strong institutions and traditions such as an extensive network of STD services, strong family planning programmes (FPP) that already promoted condom use, trained epidemiologists, health infrastructure with qualified staff, a tradition of supporting basic and applied research and the use of data in decision making, a civil society with a tradition of volunteerism, and existing network of national NGOs (Ainsworth *et al.* 2003: 18-19). Community groups and AIDS activists gained important influence in policymaking and programme design, which contributed

positively to the fight against the disease. With increased democracy in the country came also more critical views, which facilitated public debate (UNDP 2004: 2) and pushed for action. As mentioned, the work also benefited from national leadership and political commitment (and support from the army which used to have very high levels of HIV infections). There were signals from the top leadership that HIV/AIDS was a priority (from the PM office). Moreover, the National AIDS Plan was formally integrated into Thailand's five-year development plan, and by 1997 96 percent of the AIDS control budget was financed by the Thai government (UNDP 2004: 15, 17). Surveillance systems and surveys convinced the public and politicians the need for action even before the morbidity was high. The hidden spread of HIV is otherwise one of the most difficult impediments for raising awareness of the virus. The result could be seen in more condom use and drop in commercial sex leading to a decrease of new infections, and today the prevalence rate is 1.5 percent instead of projected ten percent if nothing had been done to prevent the epidemic. However, despite success, there have been setbacks. For instance, the Asian Financial Crisis (AFC) led to severe cuts in spending on HIV/AIDS prevention (by 2001 the funding was less than half the 1997 level). But in 2003 the Global Fund to Fight AIDS, Tuberculosis and Malaria provided funding to reach three quarters of the 1997 level (UNDP 2004: 36; 67).

To sum up, HIV/AIDS was detected in the middle of the 1980s, but it was not until 1988, when it was noted that the epidemic started to spread at an alarming rate and it became obvious that the epidemic threatened the lucrative tourist sector, that the virus was put on the political agenda. HIV/AIDS quickly became a priority for the government, and comprehensive programmes and policies were developed and implemented—facilitated by already existent infrastructure. The strategy to involve the whole society, from high politicians to individuals at grassroot level, was successful in bringing down the transmission rate. The democratisation process with an active role of the media, and possibilities for community groups and activists to participate in policymaking not only improved the policymaking but also opened up for crucial feed-back.

Burma/Myanmar

Burma/Myanmar, as well, has one of the highest rates of HIV/AIDS infection in Asia, 1.2-2 percent (of a 50 million population). The infection rate among injecting drug users is high, even if the main mode of transmission is sexual

(but as many as 90 percent of the injecting drug users, IDUs, are HIV infected in certain areas. ICG 2004: 3). However, on the contrary to Thailand, Burma/Myanmar has been slow to take proper action to halt the epidemic. Considering the high rates of infection together with the inapt response to the epidemic, Burma/Myanmar is considered to be facing considerable problems—with obvious spill-over effects in the neighbouring countries (cf. Safman 2005). For example, there are as many as 800,000 Burmese seasonal migrants to Thailand, and the highest rates of HIV/AIDS can be found along the Eastern borders towards China, Laos, Thailand (James 2005: 72).

The first screening programmes in Burma/Myanmar were initiated in 1985, but no cases were found until 1988 (Beyrer 1998: 40). The first AIDS patient was identified in 1991 (an IDU) (James 2005: 71). After years of inactivity the junta finally has acknowledged the seriousness of the epidemic and help from outside has been allowed. As a result health professionals, international organisations and donors have begun to coordinate their activities and funding has increased. There is a national AIDS programme, and now not only the Ministry of Health is involved in HIV/AIDS activities, but also other central Ministries are starting to become involved (even if many of these are small scale pilot activities) (ICG 16 December 2004). In 2002, the Ministry of Health, UN agencies, NGOs and other partners developed a joint programme to work against the epidemic. The Fund for HIV/AIDS in Myanmar (FHAM) was established to support the Joint Programme by contributions from different donors, and since 2003, Burma/Myanmar has been able to significantly raise the resources for the response to the HIV/AIDS epidemic through the fund (www.unaids.org). The government also announced an official HIV/AIDS prevention, control and management policy. A National AIDS Committee receives policy guidelines from the National Health Committee, which is the supreme decision-making body regards to health matters in the country. According to the Ministry of Health, active surveillance of AIDS and STI has been undertaken since 1985, but the numbers reported are far below the ones reported by UNAIDS and WHO (James 2005: 64, 71-72).

A huge problem is the seriously mismanaged economy, and the dangerously low government spending on health and education (see e.g. ICG 2004). In addition, work with HIV prevention and treatment is suffering from a lack of resources and knowledgeable personnel, and the implementation capacity of any programme is low (ibid; also see James 2005: 72-73). Most people living with HIV/AIDS (PLWHA) have to pay for their own (private) treatment.

Recent reports claim that due to the economic crisis in the country, more Burmese women turn to the sex industry in order to survive and to support their families (Shah Paung, Irrawaddy.org, 11 November 2005). Also, the 100% condom programme launched in 2001 does not seem to have the wished for effects (UNAIDS WHO AIDS Epidemic Update Dec 2005).

The political situation in the country is not making it easy either, and even though the international community has increased its contact with Burma/Myanmar, Aung San Suu Kyi and others continue to urge the international community to maintain sanctions against the regime until the results of the election in 1990 are acknowledged. It should be pointed out though, that Aung San Suu Kyi has voiced her support for the "Joint Program of HIV/AIDS in Myanmar". In addition civil society is weak. Even so, according to informants it is difficult to work with the government, and most work go through NGOs. In August 2005, the Global Fund decided to terminate its planned 98 million USD five-year grant due to travel restrictions within Burma/Myanmar (even if some believe that the real reason is because of pressure from US interests) (http://www.unandaids.org, November 18, 2005).

To sum up, Burma/Myanmar set up an institutional framework for HIV/AIDS at an early stage, but it was not until relatively recently that the HIV/AIDS epidemic was prioritised by the government. There are strategies to combat the disease but much of the work is externally driven, and implementation is made difficult by the socio-economic and political situation in the country. Burma/Myanmar is probably the country in the region facing the largest challenges in combating HIV/AIDS.

Cambodia

Cambodia has the highest HIV prevalence in Asia: 1.9 percent (of a 15 million population). Cambodia is pointed out as another example of success. Again political will is one of the most important contributing factors together with the inclusion of civil society in the combat of the disease. Cambodia has been successful despite widespread poverty and domestic political turmoil, something that will be discussed more in detail later.

The first HIV case was detected in 1991 during screening of blood, and the first AIDS case was diagnosed in 1993 (UNAIDS 2004: 9), and the same year a National AIDS Committee was established. But it was not until 1995 the seriousness of the epidemic became clear. The committee was reorganised and the prime Minister became the Honorary Chairman. In 1999 the National

AIDS Authority (NAA)[6] was established, and a comprehensive and multi-sectoral strategic plan was developed (Reid and Costigan 2002: 42, 44) coordinated by the NAA (NAA is separate from the medical programme but belong to the Ministry of Health. Wågberg 2003: 6). What was until recently unique for Cambodia, compared to the neighbouring countries, was a Law on the Prevention and Control of HIV/AIDS that was promulgated and passed in 2002 (No.NS/RKM/0702/015) (today Vietnam has a law as well). Cambodia is also considered to have one of the most advanced surveillance systems globally among less developed countries (UNAIDS 2004: 10).

NAA has developed a National Strategic Plan (NSP) for a multi-sectoral response including all ministries, and there is a wide range of policy initiatives related to HIV/AIDS (UNAIDS 2004). HIV/AIDS is also included in the Health Sector Strategic Plan 2003-2007. The goals of the national response to HIV/AIDS are: to reduce the new infections of HIV, to provide care and support to PLWHA, to alleviate the social-economic and human impact of HIV/AIDS on the individual, the family, community and society (UNAIDS 2004: 41). There has been a shift from a health centred to a people centred and gender sensitive approach, and from a top down to a bottom up approach emphasising human rights (No. NS/RKM/0702/015; "complementary code of conduct").

The presence of external actors in Cambodia has been large ever since the UN operation at the beginning of the 1990s (UNTAC). The result is that services are by and large donor driven, and goals are set up by the donors rather than from a nationally defined strategy. An additional problem related to this is the limited number of skilled adults in Cambodia, i.e. the lack of human resources, which puts Cambodia in a vulnerable position. The Khmer Rouge managed to destroy not only family fabric, but also generations of educated that should have played an important part in the development of the country. Added to this, an increasing mortality rate may lead to serious consequences in terms of foregone development opportunities (UNDP 2004: 5). Also, as one of the poorest countries in the world, there are implementation difficulties due to the lack of resources in the rural areas.

To sum up, HIV/AIDS was detected relatively late in Cambodia, but once it came on the agenda the efforts to halt the epidemic have been comprehensive and far-reaching. Similarly to Thailand, political commitment

[6] The NAA consists of a secretariat, 26 line ministries, the Cambodian Red Cross and 24 provincial committees. The role and responsibilities of NAA is policy development, strengthening partnership and coordinating the multi-sectoral responses to HIV/AIDS, mobilising resources, advocating legislative support for research on the socio-economic impact of HIV/AIDS, and reviewing and approving the IEC programmes in all sectors (UNAIDS 2004: 41).

and the inclusion of civil society have played a crucial role in the combat of the disease. What differs though is the pronounced presence of international development cooperation, and low level of socio-economic development that increases the vulnerability to HIV infection and hampers the implementation of the HIV/AIDS strategies.

Vietnam

Vietnam has a relatively low rate of HIV/AIDS infected, 0.4 percent. However, the number is on the rise, and as the population is big, more than 80 million, the number of infected is relatively large. Also, about 60 percent of the infections are related to drug use, mostly heroin, which is different compared to the other four countries.

The authorities in Ho Chi Minh City reported the first HIV case in 1990 and the first AIDS case in 1993 (Blanc 2004: 153). In 1987 a sub-committee for SIDA prevention and control was set up to be replaced by the Vietnam National Committee for Prevention and Control of Communicable Diseases in 1990. In 1994 the committee was separated from the Ministry of Health to be chaired by a Deputy Prime Minister (but with MoH as its standing body). In 2000 the National Committee for AIDS, Drugs and Prostitution (NCADP) replaced the previous National AIDS committee and the committees on illicit drugs and prostitution (The National Strategy on HIV/AIDS Prevention and Control 2004: 122; Khuat Thu Hong *et al*. 2004: 5).

There has been less official denial than in many other Asian countries (even compared to Thailand). The government has no religious constraints, and condom advertising and some needles sharing programmes are allowed. However, the policy of "social evils" has worked against HIV/AIDS prevention, as HIV/AIDS has been connected to prostitution and drug use (see e.g. Templer 1998: 241; Khuat Thu Hong *et al.* 2004). The government has acknowledged the problem, and now policies against discrimination have been pursued, and in June 2006 the Law on HIV/AIDS Prevention and Control was approved. The law includes supplements to previous legal documents (VNA 19 August 2006). Thus, Vietnam has developed a legislative framework to support their activities, and accordingly it is, for example, forbidden to refuse to treat people living with HIV/AIDS (Khuat Thu Hong *et al.* 2004: 6).

The goal is to get down to a HIV/AIDS prevalence rate of 0.3 percent. In a recent UNAIDS press release, Vietnam is praised for adopting an evidence-based and progressive National Strategy on the Prevention of HIV/AIDS,

which "stand as a model for other countries in the region and in the world" (18 October 2004). According to an informant there is more policy ownership in Vietnam than in, for example, Cambodia. In Vietnam there is a strong tradition of being independent and not ruled or influenced by other powers, while in Cambodia the international presence in policymaking is very pronounced (personal communication March 2005).

Still, according to Dr Tran Thi Trung Chien, Minister of Health, there are a number of difficulties to address: HIV/AIDS continues to be considered a "social evil" at the grass-root level, not all HIV/AIDS activities have been invested in, there is a lack of legal framework and consensus in implementation issues (e.g. on condom programme and syringe exchange programme), there is still plenty of discrimination and stigma, care and treatment is not working (speech 25 August 2004). In a speech by the President Tran Duc Luong, other difficulties were pointed out: the party and the local authorities "sometimes disregard and do not concentrate on the leadership". Moreover, the mass organisations do not cooperate like they ought to (25 August 2004). The Commission for Ideology and culture acknowledge that the reason why Vietnam has failed to control the epidemic is that there is a gap between knowledge and behaviour, that there is not enough information communicated about HIV/AIDS, and that the time for implementation is too short (report from conference "renovation of the communication on HIV/AIDS prevention and Control, 1 August 2004). Lately worries have been expressed because of the increase of IDU and HIV/AIDS infected in the poor northern highlands (Agence France Press August 22, 2006).

Nevertheless, during my visit to Hanoi in March 2005 the impression I received was that rapid improvements are on the way—much because of the new national AIDS strategy adopted in March 2004. The discussions are more open, the decentralisation is increasing with the result that some provinces are even more progressive than the central level. Interestingly, Vietnam has, as one of fifteen primarily African countries, been selected for President George W. Bush's Emergency Plan for AIDS Relief (PEPFAR) due to the expected increase of infected. But also other donors increasingly support Vietnam.

To sum up, Vietnam was relatively quick to respond to the HIV/AIDS epidemic in the 1990s and health policy is moving quickly now. However, despite much praised policies, political and administrative structures and organisation together with the legacy of the "social evil" campaign where HIV/AIDS became strongly associated with drug use and prostitution hamper

the implementation. Vietnam is pointed out as the next "hot spot" for the epidemic due to the high rates of IDUs (among youth especially) and the increase of sex work. At the same time Vietnam is in many ways better equipped to meet the epidemic than Burma/Myanmar, Cambodia and Laos due to a higher level of socio-economic development.

Laos

Laos has one of the lowest rates of HIV/AIDS in the region, 0.1 percent (with a population of 5.5 million). The high-risk groups are slightly different from the neighbouring countries. IDUs are not common in Laos, and there are higher rates of HIV-infection among migrant workers than among sex workers (50% of the infected are migrant workers returning home. UNAIDS 2004: 143). Thus, except for specific groups, such as the wives of farmers who migrate to other countries for seasonal jobs, the general population is not considered to be at risk of HIV.

The first HIV case was reported in 1990 and the first AIDS case in 1992. According to UNDP, the HIV/AIDS epidemic is well managed in Laos (www.undplao.org). Laos has both a National Committee for the Control of AIDS (NCCA) (established in 1988), a National HIV/AIDS/STI policy (2001), and a National Strategic Plan on HIV/AIDS/STI covering 2002-2005 (it was being revised during my latest visit to Laos). The Lao PDR's National AIDS Programme takes a multi-sectoral approach. The National Committee for the Control of AIDS consists of 14 members from 12 line ministries and mass organisations and is chaired by the Minister of Health. There are also committees at the provincial levels (MDG report 2004). However, the absence of a comprehensive surveillance mechanism makes it difficult to know how many are infected (www.youandaids.org). As the prevalence rate is low in Laos the focus has been on transmission. Accordingly, the National Action Plan has a strong focus on prevention activities. The low prevalence has also led to less support from the international community (and the government is very dependent on donors for HIV/AIDS related activities). This is a cause of worry since the chances for stopping the epidemic at an earlier stage diminish. In addition most projects focus on the cities and are short-term (personal communication Vientiane March 2005).

There are several factors influencing the future development of the epidemic in Laos. For instance, in general people know about HIV/AIDS, but they do not know how to use a condom (e.g. it is believed that demonstrating condom use in schools encourage sexual activities). It is possible to work with sex workers despite sex work being illegal, probably facilitated by the fact that the

sex workers primarily are from Laos and not afraid of being deported. At the same time it is difficult to target the increasing number of mobile sex workers (personal communication Vientiane March 2005). Low-skilled girls working in garment factories are at risk of becoming new sex workers because of low educational levels and low salaries, and government employees are at risk during travel to the provinces because of the per diem they earn. This group is difficult to target due to sensitivity (personal communication Vientiane March 2005). But on average, Lao tend to have fewer sexual partners than in the neighbouring countries, which probably contributes to the low level of infections (Urwitz and Nyman 2002: 61). Another explanation is, according to UNAIDS, that most migrants only visit sex workers while away from home with the result that "only" the family members get infected (personal communication Vientiane March 2005).

To sum up, there are policies and strategies in Laos, but the lack of funding may threaten the low level of HIV infections. At the same time, with the right action Laos has the potential to remain a country with a low HIV/AIDS prevalence rate.

Country	Infection rates	First HIV and AIDS cases (X/X)	Type of transmission (primary)	Policy response (first initiative/ committed)	Civil society	Healh care system	Role of donors
Thailand	1.5%	1984	Sexual/ IDU	1987/1991	Strong	High level	Not very important
Burma/ Myanmar	1.2-2%	1988/ 1991	Sexual/ IDU	2002	Weak	Weak	Important but limited
Cambodia	1.9%	1991/ 1993	Sexual	1993/1995	Rel. strong	Weak	Crucial
Vietnam	0.4%	1990/ 1993	IDU/ Sexual	1987/1994	Mass org.	Average	Important
Laos	0.1%	1990/ 1992	Sexual	1988/2001	Mass org.	Weak	Crucial

Table 1. Summary of the five countries

What makes some strategies more successful than others?

Scope and type

It can be noted that the scope and type of epidemic to differs between the countries, which naturally have effects for the policy process and whether the policies and strategies are successful or not (see Table 1). The stage of the epidemic influences whether the focus is on prevention and/or treatment. For example, while in the countries with mature epidemics both elements are included, in Laos prevention is prioritised for obvious reasons. In three of the countries the epidemic is generalised while in Vietnam and Laos most of the infected belong to groups with high-risk behaviour such as IDU, sex workers or migrant workers. This also implies that the primary target groups of the policies vary. The strategies to fight the epidemic can be single- or multi-sectoral. While the latter focus is adopted in most strategies in line with international recommendations, in practice the Ministry of Health is the main implementation agency. In all countries the governments play a leading role in the fight against the disease, but all but Thailand have been and still are very dependent on international funding (and expert advice). Finally, the way AIDS is defined affects the policy, if it is narrow or widely defined (e.g. as a medical or societal problem). In general, it is now acknowledged that HIV/AIDS is not only a medical problem, hence the multi-sectoral approaches. Thus, it is obvious that the governments have reacted to the epidemic in different ways, and that some can be explained by the scope and development of the epidemic. At the same time one can see similar trends regards the focus on multi-sectoral approaches, the establishment of AIDS committees, improved policy-ownership, etc. However, there are some issues related to the "success" of policies that show the difficulties in assessing the policies. These will be problematised below.

Framing and perceptions

In general, the broader the societal involvement and the higher the epidemic is prioritised politically, the more efficient are the policies (this includes funding). The degree of openness and pragmatism, in the sense of working with groups with high-risk behaviour such as sex workers and drug users (despite criminalisation), also appears to be decisive for success. Another crucial factor is education, information and the role of media. If people are unaware of the risks of infection and how to protect themselves, policies are very unlikely to have any effect at all. A functioning health care system contributes substantially to reducing the infection rate. An additional reason for success could be—besides generous donor funding—the number of IDU.

For example, there are few IDUs in Cambodia, and the policies regarding illegal drugs and HIV/AIDS prevention do not collide as in, for example, Thailand. In general, a major reason for difficulties in combating the virus is the illegal status of drugs, and that governments often have been more concerned with the legal aspects of drugs use than the effects on public health (see Reid and Costigan 2002: 14). Also, the sex workers are more controlled by the authorities in Thailand and Cambodia than in, for example, Vietnam.

Denial and silence from political leaders influence the fight against HIV/AIDS negatively—particularly at the beginning of the epidemic, as for instance in Burma/Myanmar. To associate HIV/AIDS with "social evils", as in Vietnam, only increases the stigma and thus fuels the epidemic. Moreover, stigma and social evils campaigns make people believe they are not in the risk zone, since the gap between "us and them" gets wider. Some of the difficulties in implementing the policies can be attributed to the lack of resources in general and in the health sector in particular (as much of the activities are under the responsibility of the ministries of health), but the way policy is designed has consequences for the implementation too. If the target group is negatively constructed or associated with "moral panics", as sex workers or drug users often are, the policy choices may not be optimal for implementation, or they become targets of punitive public policies (Nicholson-Crotty and Nicholson-Crotty 2004). This applies to Vietnam, for instance, even if Vietnamese leaders have started to visit HIV positives to lessen the stigma (personal communication Hanoi 2005). Also, in the official discourse, the increase of infections is often seen as a result of changing lifestyles (as part of modernisation), but the problem is of course more complicated than that. For instance, ignorance and poverty are part of the problem together with gender roles. Gendered inequalities prevent women negotiating safe sex, and many young girls and women are forced into sex work as a means of survival—for themselves or their families—increasing the risks for infection (Jönsson forthcoming).

Another factor influencing whether we see policies as successful or not is reduced numbers of infections. However, there are many uncertainties surrounding the statistics. The surveillance systems may be inadequate, and infection rates may be underreported due to the sensitivity of exposing the infected to stigma and discrimination. Furthermore, numbers can easily be manipulated. The numbers of infected may be under-reported but they may be also over-reported to obtain funding. Here it is interesting to take a look back some ten years at the HIV/AIDS situation at that time. By the end of 1994 there were 14 million HIV-infected and one million AIDS-cases had

been reported to WHO—even if WHO estimated the real number to 4.5 million due to under reporting. The projections at that time predicted that between 40 and 100 million would be infected in 2000 (Jönsson and Söderholm 1995), compared with the 40 million in 2006. Albeit still too high from a human point of view, the number of infected luckily landed at the lower end of the prediction.

Nothing is static

But even if we, with these reservations in mind, accept that some policy measures are more successful than others—such as those taken in Thailand—we do not live in a static world. The epidemic changes together with the society at large with consequences for policymaking, and previous success may be jeopardised. As the epidemic spreads more generally in the population—making especially couples and youth vulnerable—it will be harder to detect and prevent new infections. A major concern is the practice of unsafe sex and increase of drug use among youth. Studies in Thailand show that the awareness of how HIV spread is alarmingly low among the young (see e.g. UNDP 2004). What is worse, even if people do know how the disease is transmitted, they think that they will not get infected themselves. The 100% condom campaign reduced the visits to sex workers, and young men started to date their female peers instead. The problem though, is that these young couples often practice unsafe sex. In addition, the 100% condom campaign does not reach indirect sex workers or migrating sex workers, which means that there are still high levels of infections rates among certain groups. Today half of the new infections occur between men and their spouses or girlfriends (UNDP 2004: 45), and in total one third of the infected in Asia today are women (ibid: 51). In Cambodia, new infections among women are estimated to be five times as high as new infections among men (MoH/NCHADS 2002: 23), and the rates among sex workers who started to sell sex less than a year ago is high (29%). In addition, the practice of "sweethearts" increases the risk of transmission, as many do not use condoms (see Wågberg 2003: 7). Men who have sex with men (MSM) are also increasingly spreading the virus due to low condom use in this group—at the same time as many of these men practice sex with both men and women. Despite the advanced surveillance system in Cambodia, staff at the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) acknowledged that there is a need for more information about MSM, drug users, migrant population and indirect sex workers (many in the garment industry) (personal communication March 2005).

Another worry is the consequences of a mature epidemic, with increasing numbers of orphans together with costs for treatment and long-term care of the infected. Until now, most orphans in Thailand are taken care of by relatives, or orphanages or temples take care of them. However, already now many of the orphans slip through these nets (UNDP 2004: 62), and there will probably be more in the future as the mortality rates increase. Also in Cambodia the number of orphans is increasing along with the mortality rates (personal communication Phnom Penh March 2005). In Cambodia this is especially problematic as many grandparents, who in many places would be those taking care of the orphans after the parents are dead, are missing due to the terror of the Khmer Rouge. The costs of treatment and antiretroviral therapy (ARV) are increasing as well (even if Thailand produces its own ARV for 300 USD per patient and year), and multi-drug resistance is putting more pressure on already fragile health care systems. Also, it is extremely difficult to develop a vaccine and even to produce ARV that will prolong the lives of HIV/AIDS infected. The geographic variation of the HIV virus generic make-up will make country-specific vaccines useless globally (Archibugi & Bizzari 2005: 40)—if they ever are found. It is also very controversial to test vaccine (see e.g. Kallings 2005).

Worries have been expressed that Asia will be the next "hot spot" of HIV/AIDS considering the increasing rates of infection, but according to Daniel T. Halperin and Helen Epstein (2004) it is not sure at all that large-scale heterosexual epidemics will occur in most parts of Asia. They argue that it is the length of relationships that matters. In Africa it has been observed that men and women often have two or three parallel relationships, and that these can overlap for long periods of time (months and years). This can be compared with the practice of serial monogamy, which is common elsewhere. The problem with long-term relationships is that it is harder to consistently use condoms, and consequently most of the infections take place within such long-term relationships. This has of, of course, implications for prevention activities. For the case of Vietnam, which is considered to be one of the "hot spot" countries in Asia, Mensch *et al.* (2002) argues that the fear that young girls are especially at risk is an overreaction caused by too limited research. Others argue that as the epidemic in Asia is concentrated to groups with high-risk behaviour that can be targeted, it will not be "generalised" as in, for example, Africa. Moreover, women's sexuality is curtailed by social and cultural factors (Goodwin *et al.* 2006).

To sum up

The success in halting the epidemic has many causes and is dependent on a number of factors, many of them beyond the direct scope of HIV/AIDS policies. The picture that is emerging is ambiguous, leaving no definite answers. Success is a relative concept implying that "successful policies" are not constant but must be related to context as well as to societal changes—both at local and global levels. Nevertheless, it is important that the epidemic is acknowledged as a real problem in order for it to find a place on the political agenda. Here the framing of HIV/AIDS is crucial, together with pressure from the local society as well as from external sources. Policy formulation is dependent on who is allowed to participate in the process, and the more input from society, the more successful the outcome. But regardless the of existence of good policies, the real obstacle for success is implementation at the local level. This can be due to lack of resources and human capacity, but also due to societal changes making policies obsolete. Feed-back and learning from previous experiences are also important, but it appears that people quickly forget endangering previous success. In other words, despite improvements in HIV/AIDS policymaking, much remains to be done in all five countries. It appears though, that the current focus on HIV/AIDS at the global agenda has created a window of opportunity to take more firm action.

The policy environment

So far the discussions primarily have concerned the development of the HIV/AIDS epidemic and the policy responses in the five countries. But these policies do not exist in a vacuum. In order to understand why some countries have fared better than others, we must have a closer look at the policy context. It is important to acknowledge that each country has its own political environment and HIV/AIDS policy trajectory, which must be related to international guidelines and what is considered to be "successful" policies. Often political will and an active civil society are pointed out as some of the most important factors for success, as in the Thai and Cambodian cases, but as Parkhurst and Lush (2004: 1915) argue, more institutional factors such as political, bureaucratic and health systems, play a crucial role as well. As it turns out, the most successful measures have been carried out among affluent people and countries leaving many poor countries and groups of people with increasing infection rates (Allen 2004).

Political system

To start with, the political system sets the boundaries for the policymaking process by determining who is involved in the political system, and who makes the decisions (i.e. how democratic the system is). It also determines how the decisions are taken and disseminated, and if there are any discussions about alternatives (i.e. if the system is liberal or authoritarian). Another factor influencing the policies is whether the system is egalitarian or inegalitarian, i.e. if the aim of the policy is to distribute goods and services or maintain inequalities (Blondell in Walt 1994: 19). These boundaries leave their marks on the policy process.

The political system differs in the five countries, obviously affecting the HIV/AIDS policymaking process. As mentioned, Thailand's success has to a great extent been attributed to the democratic processes, where many actors could participate—including actors from civil society and the media. [7] Also, Thailand democratised in 1992, which facilitated this process. Burma/Myanmar is ruled by decree and there is no civil constitution, narrowing down the political space considerably. Nonetheless, according to James (2005:62) there is an evident partnership between the state and civil society in the health sector in Burma/Myanmar. Cambodia reluctantly adhere to democratic practices, and the country is still very centralised and in many ways authoritarian. But in the health care field, including HIV/AIDS, there are opportunities for NGOs to give input to policymaking at the technical level (personal communication March 2005). Laos and Vietnam are authoritarian one-party states where the government and party have enormous power penetrating the society, and media and organisations are under tight control. An independent civil society does not exist to express the demands and wishes of the broader rural population (Jørgensen 2005: 335)—instead mass organisations serve as the link to the people. Consequently the policymaking is very centralised and also opaque for outsiders, especially in Laos since Vietnam has initiated an administrative decentralisation process and devolves decision-making power to the provinces (Regional Outlook 2006: 58). National NGOs are not allowed, and the international NGOs are less independent in Laos and Vietnam, than in, for example, Cambodia. In Cambodia, "*most* NGOs comply with the government's strategies and planning" (personal communication MEDiCAM, Phnom Penh March 2005) indicating a more relaxed attitude towards NGOs. However, it seems that

[7] According to Freedom House, which measures political rights (PR) and civil liberties (CL) from 1 representing the most free to 7 representing the least free countries, Burma/Myanmar gets 7 on both PR and CL, Laos and Vietnam get 7 and 6, Cambodia 6 and 5, and Thailand, which is the only country of the five considered to be free, gets 2 and 3 but is moving towards less free.

HIV/AIDS has tested the Vietnamese government by pushing the boundaries of acceptable policies concerning the emergence of civil society working with HIV/AIDS issues (Templer 1998: 238). Egalitarianism used to be part of the political ideology in Vietnam, Laos and Cambodia, but today's move towards market economy—with inadequate safety nets and opportunities for a few to become very wealthy—has actually left these societies more unequal than before. For instance, the Lao policy reform has in practice "resulted in a highly inequitable system where those better off have access to unlimited quality care options, while the poor's access to health care is very limited" (Paphassarang 2002: 82). However, the governments have acknowledged this, and measures are currently underway to improve the situation for the poorest in society (e.g. through poverty reduction programmes and health insurance schemes). In Burma/Myanmar the military regime provides for its own supporters, while the majority of the population is impoverished. In Thailand, which is more affluent than the other four countries, there is still a wide gap between rich and poor. All five countries are elitist in character, regardless of political system, which to various degrees colours the opportunities to participate in the policymaking processes.

But the question remains: why these policies and why at that time? If we let the Kingdon model guide the analysis, a few issues are highlighted. It is obvious that in order for anything to happen the HIV/AIDS epidemic it must be perceived as a real problem. There must be a policy solution at hand, and the politicians must be ready to deal with the issue. When these three streams meet there is an opportunity for change, which can explain why some countries have waited to take action despite early HIV cases. For poorer countries the possibilities of external funding are of course part of the solution, which also means that external actors have a say regards what policy solutions to choose. A more liberal society can help to push for change by putting the issue on the political agenda forcing the governments to take action—for example by media and NGOs—as in Thailand. Cambodia, Vietnam and Laos have had opportunities to learn from more experienced countries. In other words, in the case where the three streams have met the fight against HIV/AIDS has been more efficient than in those where a stream has been "weak" or lacking. Moreover, external actors and the increasing focus on HIV/AIDS globally contribute to putting HIV/AIDS on the national agenda (not the least through the fulfilment of the MDGs).

The actual policy formulation is influenced by the stage of the epidemic, participating actors and so on. The Thai government had the capacity to deal with the epidemic, but in Vietnam, Laos and Cambodia, foreign experts have

been instrumental in developing HIV/AIDS policies. According to an informant, Vietnam has more ownership than Cambodia, and in Laos the policy and strategy are under revision with an external consultant acting as a facilitator, rather than writing the plan as the previous time, in order to increase ownership (personal communication Vientiane March 2005). While I do not know exactly how, and on what basis, the policy decisions were made in the five countries, there are few issues worth discussing due to the prominent role external actors play in aid dependent countries.

In general, political and economic history is often ignored during the design of HIV/AIDS programmes. Interests inform decisions, i.e. what there is to win and loose, and various trade-offs influence decision-making. According to Barnett and Whiteside (2002: 336) any governmental HIV/AIDS policy document typically includes everything that might be done to fight the disease. The choice is reinforced by technical best interventions and by international donors mainly supporting their own preferred interventions and mandates. For example, PEPFAR has been heavily criticised for its impact on lessen the funding of family planning and reproductive health, distribution of condoms and sexual education. So even though the funding for HIV/AIDS has increased considerably, one third is for abstinence and very little passes through international organisations and only to a few selected countries (Kallings 2005: 162). Moreover, objectives are expressed in terms of programme components rather than outcome. Instead of ranking programme elements according to their effect on the overall epidemic, given their costs, many activities and pilot projects are chosen on the basis of political support and that they are the least controversial. For instance, in many places those who are likely to have the biggest impact on the epidemic, i.e. those who transmit the virus to others, are the lowest on the political agenda. The 100% condom campaign among sex workers in Thailand and Cambodia is an exception, but even so MSM are still neglected. The fact that many officials spread the virus has not received much attention either. Thus, the way policy-decisions are made and what kind of interests that are represented obviously affects the outcome of the policy process.

Bureaucratic system

Although HIV/AIDS today is on the agenda in all five countries, there are administrative and organisational obstacles that prevent efficient implementation. In some cases this is due to hierarchical political structures with little room for criticism, or simply because of inaccessible terrain and lack of communication infrastructure reducing the state presence, which leaves the execution of decisions much in the hands of regional and local

political forces and bureaucracies (cf. Hall and Midgley 2004: 13)—as for example in the Vietnamese case. Even in *Thailand* there are administrative obstacles to tackle. The authority of the current National AIDS Committee is unclear (UNDP 2004: 4), and the office of the prime minister no longer actively leads the response to HIV/AIDS. Other ministries have become weaker in their participation due to lack of resources. In other words, the multi-sectoral approach is no longer efficient (UNAIDS/04.35E).

The civil bureaucracy in *Burma/Myanmar* has been described as "poor organization; decision-making processes that are at times irrational and arbitrary; mismanaged, undertrained and underutilized staff; weak accountability mechanisms particularly in the higher ranks dominated by deputized military personnel; poorly designed public policy programmes; and badly implemented public services" (Mutebi 2005: 141). In addition, policy and management of HIV/AIDS prevention, control and treatment are very sensitive (James 2005: 72), which obviously makes the work to combat the epidemic even more complicated. Recently Burma/Myanmar lost much needed 98 million USD from the Global Fund because of denied access to parts of country (http://www.unandaids.org, November 18, 2005).

A key challenge to the fight against HIV/AIDS in *Cambodia* is structural, i.e. a weak state and a bureaucracy surrounding the work that hamper efficient implementation. For instance, coordination within and among intra and inter-agency technical and operational units is problematic (e.g. different ministries, within the Ministry of Health, and with external partners) (UNAIDS 2004: 2-3)—especially since the NAA is under-resourced (NAA 2001: 9). The centralistic nature of governance makes the decentralisation of resources difficult (UNAIDS 2004: 3). The civil servants cannot survive on their regular salaries but must have additional income from other jobs, and at provincial and district levels HIV/AIDS related work is added to the original workload without any compensation. The lack of human resources is also a problem together with the difficulties of pursuing a multi-sectoral approach (NAA 2001: 30-31). The Cambodian culture has been described as "hierarchical, top-down oriented and insensitive to human needs (and human rights), while at the same time being unable to exercise efficient governance" (Öjendal 2005: 296).

In *Vietnam* the national AIDS programmes have been restructured many times over the last years (Wågberg 2003: 8), and it appears that some of the difficulties in implementing the National AIDS Programme at the provincial and local level to a large extent can be ascribed to the constant changes of organisation and the delay of necessary documents, i.e. overlap and conflict

between documents (UNDP 2002: 18). The legal corridors exist, but they are difficult to translate into practice (personal communication March 2005). Despite decentralisation, in general "there still exists a top-down structure where orders come from above and where the local village meeting can only decide methods of implementation. In other words, the mandate of the people in relation to the state and the party is both limited and unclear" (Jørgensen 2005: 323). Overlapping responsibilities have made the process complicated together with the stress caused by the large number of donors introducing diversified and complex rules related to their specific programmes. "Constrained and unstable organization, coupled with insufficient human resources, are the major factors impacting the capacity of the program" (AusAID/UNDP 2004: 50). This is not unique for the HIV/AIDS programme, but for other programmes as well. In addition, Vietnam is very "boxed" which makes cross sectional collaboration difficult (personal communication WHO, Hanoi March 2005). According to one informant, the Ministry of Health thinks more of geographical coverage than content, i.e. it is more important that there are activities in all provinces than that the activities are the most suitable ones. Also, some of the projects are short-term and not sustainable (personal communication, Hanoi March 2005).

In *Laos* recent reorganisation has made policy implementation difficult, as the organisation structure and responsibilities are not clear. The Ministry of Health has presently two bodies responsible for HIV/AIDS, the bureau at the hygiene department is responsible for policy and strategy, and the centre which is an implementing agency (and ranked below the bureau). However, the mandate has become mixed as the staff at the centre used to work at the bureau, and they continue to work as before. In Laos, provinces are strategic units, districts planning and budgeting units, and villages are implementing units. The ministries formulate policies and strategies. The districts are increasingly responsible for planning and budgeting, and "newly decentralised provincial and district health offices are struggling to cope with their increased technical and management responsibilities" (Perks *et al.* 2005: 135). According to UNDP, Savannakhet in southern Laos is the most progressive province regards to HIV/AIDS prevention (UNDP 2002: 18).

Health care system

The health care system has been identified as one of the major factors in a successful fight against HIV/AIDS. But before going into details, it is important to take a look at the health situation in general. The last decades have meant large improvements in global health. Still, today many countries suffer from the so-called dual health burden. The dual health burden is the

unfinished agenda of infectious diseases, such as malaria and tuberculosis, malnutrition and complications of child-birth and the emerging epidemic of HIV/AIDS and non-communicable diseases, such as cancer, diabetes, obesity, cardio-vascular diseases, acute respiratory disease and injuries (Bhatia and Mossialos 2004: 170). This means that the various countries are differently equipped to deal with the HIV/AIDS epidemic. And even if Asia's health systems are strong compared with, for example, Africa's the spending on healthcare varies considerably in the region. Thailand has a high level of healthcare, Vietnam an average level and Cambodia, Laos and Burma/Myanmar have a low level.[8] With shrinking public health sectors and an increase of HIV/AIDS infected, the weakness of the health care systems are exposed. For example, in all but Thailand blood security is questionable (see e.g. Wågberg 2003: v). Thailand's successful prevention strategy was to a large extent built on the existing health infrastructure, which has kept the costs down (UNDP 2004: 2). There are also other problems to deal with, for instance with scaling up ARV therapy, and not all in need can be reached. Cambodia is an exception, and according to NCHADS everyone who needs it can obtain ARV treatment, and there is sufficient funding for HIV/AIDS related activities for the next ten years to come (personal communication January 2006; also see Bourdier 2006). In Asia, only around 16 percent of the people in need have access to ARV, despite the "3 by 5" initiative (50 percent in Thailand). WHO and UNAIDS launched the "3 by 5" initiative in 2003. The idea "was to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral therapy (ART) by the end of 2005". Even if the goal was not reached on time, many countries demonstrate political commitment to the "3 by 5" initiative by producing national treatment targets (http://www.who.int/hiv/, 20 March 2006). The problem is not only to access the ARV but also to have a stable flow of the drugs at affordable prices (Shadlen 2004). The patient must take the drug regularly and be healthy enough to take it.

Also, in Cambodia low wages have encouraged many public servants to charge the public unofficial fees for their services making it difficult for the poor to manage the health costs (see e.g. Bloom *et al.* 2004: 81). In Laos and Vietnam it is common that health professionals "moonlight" in order to support their families, which means they only attend their public duties for a few hours per day (see e.g. Jönsson 2002: 141), and the health sector in Burma/Myanmar has been described as chaotic (Beyrer 1998: 11). According

[8] Total health expenditure percentage + USD of GDP/capita (2003): Thailand 3.3%/260USD, Burma/Myanmar 2.8%/51 USD, Cambodia 10.9%/188 USD, Vietnam 5.4%/164 USD, Laos 3.2%/56USD (www.who.int/countries/en/).

to WHO, in 2000, Burma/Myanmar ranked globally 190 out of 191 in health sector performance. For large parts of Burma/Myanmar's population routine health care is unaffordable. In addition, there is a lack of trained health care providers, and the government does not invest in health care (Safman 2005: 118-120). Considering that the Ministries of Health still are the main responsible agencies for dealing with the HIV/AIDS epidemic, the weak health care systems in the four poorer countries are of course problematic.

Policymaking in a globalising world

The ways we assess policies are crucial. Naturally there are some measures that overall are supportive for success, but the success of policies is very much dependent on capacity, institutional factors and the interests of the stakeholders. In other words, policy success is a relative concept. If the measure of success is primarily based on the reduction of infection rates, we miss out many other aspects. Thailand has in many ways been a role model because it has been able to achieve this. In other words, a replication of polices without considering the institutional context may create unrealistic expectations and/or lead to the belief that there are fit-for-all polices, without considering the consequences.

Re-connecting to globalisation and its effects on both the HIV/AIDS epidemic and on policymaking, one may remark that we live in a constantly changing world, and that initial success in the fight against the HIV/AIDS epidemic may fade over time (or vice versa). Some of this can be ascribed to political action (i.e. policymaking as seen above), and some of it is a result of societal processes affecting the policymaking context. It is often pointed out that globalisation can be very uneven, heavily affecting some parts of the society while other parts remain rather untouched (see e.g. Kinnvall and Jönsson 2002). The effects of globalisation are not always coherent either, insofar as capital transactions are liberalised while, for example, the movement of people and pharmaceuticals is very regulated (Barnett and Whiteside 2002: 353. For TRIPS see Barnett and Whiteside 2002: 340; Poku and Whiteside 2004: 115)—an inconsistency that has consequences for the HIV/AIDS epidemic and not the least ARV treatment. Also, production can move on short notice to increase profits, while the people loosing their jobs often are forced to migrate in order to survive. Due to strict migration laws many of these migrants work illegally and are excluded from social safety nets. Several engage in risky sex behaviour, as sex workers or sex buyers, which increase

their exposure to HIV/AIDS. Further, as the HIV/AIDS epidemic matures, more people need treatment. But the costs of ARV are still too high to be accessible to all in need—due to regulation in the pharmaceutical field, together with profit seeking companies.[9] At the same time, ARV can be bought over the counter without prescription in, for example, Cambodia. This complicates policymaking, and implementation, as policymaking and regulation (or lack thereof) at the international and national level do not always support each other—or even contradict each other. There are two sides of globalisation: disease travels faster and people are more vulnerable; information moves quickly and monitoring becomes easier (but also the spread of panic becomes quicker as in the case of SARS) (Lee 2003: 6). In other words, the degree of social cohesion and inequalities links to HIV/AIDS (Altman 2003: 43), and societies in transition are particularly vulnerable (Poku and Whiteside 2004: 11) due to rapid changes in society, at the same time as policymaking often falls behind.

Simultaneously the policymaking process is becoming "globalised" with an increasing number of and kinds of actors participating in the process raising interesting questions about where the locus of policymaking currently lies (see Hall and Midgley 2004: 1). So far, I have primarily discussed the policy process from a national perspective. However, the national policy processes are interlinked with each other through actors active in the regional as well as the global arena. Global discourses and policy diffusion also link policy processes in different countries and organisations. The global/regional/national/local linkages are omnipotent. Below the focus will shift to the many actors in the HIV/AIDS field, and to the state and its capacity to act in the field of HIV/AIDS in an increasingly complex (policymaking) world.

PART THREE: New actors and the role of the state

After having discussed different strategies to fight the epidemic and their relative success, it is time to move on to the questions: Has the epidemic given rise to new actors and collaboration patterns nationally and internationally?

[9] The pharmaceutical companies argue that patents are needed for research and development, but this is questionable as most of the drugs have been developed without patent and that much research are funded by governments anyway. Besides, the market in developing countries is marginal (see Poku and Whiteside 2004: 69, 103, 107, 117). However, while pharmaceutical companies work according to the principle profit for shareholders, HIV/AIDS has shifted the focus to the right to health (see Sell and Prakash 2004).

What is the state capacity to deal with the HIV/AIDS issues? In other words, health governance and the role of the state will be in focus.

New actors and collaboration patterns

Many actors influence the policy process. Besides the governments and their agencies, civil society, especially NGOs, and the donor community play important roles. Thus, HIV/AIDS policymaking can obviously not be confined within national borders. We can see not only an increasing number of actors but also more public-private partnerships to tackle the challenges of the epidemic, as for instance the Global Fund and the International AIDS Vaccine Initiative (IAVI) with international/global reach (see Buse 2004; Chataway and Smith 2005). This can be viewed as an example of a new type of governance in the health sector, where the government no longer is the only main actor (as assumed in many policymaking models) but a wider range of actors participate in the policymaking process (Harmer 2005; Hill and Hupe 2002: 1). The concept governance started to appear somewhere in the 1990s, and has many definitions. One is:

> Governance…is concerned with creating the conditions for ordered rules and collective action, often including agents in the private and non-profit sectors, as well as within public sectors. The essence of governance is its focus on governing mechanisms – grants, contracts, agreements – that do not rest solely on the authority and sanctions of the government (Milward and Provan in Hill and Hupe 2002:14-15)

The shifting focus to governance has consequences on how we view policymaking because new actors become relevant in order to understand the policy process. It also highlights the importance of grants, contracts and agreements in the field of HIV/AIDS that affects the policymaking process.

According to Pierre and Peters (in Hill and Hupe 2002: 180-181), contemporary governance has a "multi-level character where international, national and sub-national processes of governance are interlinked in a negotiated fashion". International organisations take over some of the tasks that were previously the responsibility of governments. Issues can move up or down, and if they move to the private sector they move out. Governments, international organisations and other nongovernmental actors all make demands; they frame goals and make priorities, and they push for policies they

prefer. In other words, non-state actors are often involved in drafting policies, they introduce practices, rules and norms, and they set agendas (cf. Jönsson 2002). Furthermore, they set boundaries of action and guarantee contracts, issues that traditionally have been associated with the state. In this sense, hierarchy is not a precondition for governance (Bexel 2005: 55-56). One may thus talk about privatised governance, where private agents are acting as policy advisors and are involved in policy formulation and implementation. In other words, non-official implementation of official policy is taking place through, for example, aid to NGOs. Actors like the Ford Foundation (and Rockefeller Foundation) play an important role in this process (see Scholte 2000:152-156). In the field of HIV/AIDS there are organisations that in a short period of time have developed far-reaching networks across the globe. For example, the UN Theme Group on HIV/AIDS[10] can be found in 134 countries, and in 60 of those UNAIDS Country Coordination facilitates the work of the theme group—compared with WHO's 192 members (www.unaids.org/en/about /unaids/).

In other words, globally there is a vast and ever growing number of actors in the field of HIV/AIDS. In the Southeast Asia, the major donors and international and financial agencies are: USAID (USA), DFID (UK), JICA (Japan) and AusAID (Australia). UNAIDS has provided much of the leadership. Major INGOs working in the region are: the International Federation of Red Cross/Red Crescent Societies, Population Service International (PSI), Family Health International (FHI), Population Council, Pathfinder, Alliance, ECPAT, MSF, Norwegian Church Aid, CARE, Diakonia, and Save the Children. The strongest are Red Cross, FHI and PSI (Wågberg 2003: v-vi). There are also several regional networks. Since 1999 ASEAN have been involved in combating HIV/AIDS.

In Thailand NGOs working with HIV/AIDS started to appear in the 1990s. In 1999 there were 373 organisations (UNDP 2004: 37), and today there are around 800 (personal communication 2006).

In Burma/Myanmar there are over 50 domestic and international NGOs primarily working with health, health education and welfare—including AIDS prevention and control. Also professional and faith-based groups are active. These NGOs are supplemented by UN organisations (James 2005: 57-58). In 2001 there were 16 National and international NGOs working with HIV/AIDS related issues, albeit on a very small scale (Reid and Costigan 2002: 147). UNAIDS, UNDP, UNDCP, UNICEF, ADB, the government

[10] Joint HIV/AIDS policy and strategic decision-making body of cosponsors and other UN system agencies at country level (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODS, ILO, UNESCO, WHO, World Bank).

of Thailand, Rockefeller Foundation, Save the Children, World Concern, Care, World AIDS Foundation, and the Japanese Foundation to name a few, are also active in the field of HIV/AIDS (James 2005: 58; Safman 2005: 133).

In Cambodia there was an increase of HIV/AIDS in 1997, and consequently there was an increase of NGOs in 1999. Today there are more than 80 organisations working in the field. The biggest national organisation is KHANA, which is a coordinating, funding and capacity building organisation for local NGOs. Other big players are Family Health International, World Vision and MSF from France and Belgium (personal communication Phnom Penh March 2005), and PSF, CARE, Centre of Hope, PSI, MdM, URC, POLICY (Strategic Plan 2004). The international donors fund the majority of the HIV/AIDS related activities (previously WB credit, currently ADB and WB Grants, plus DFID and CDC-GAP grants provide for the majority of the governments input. Strategic plan 2004: 2). Other bilateral donors are France, EU, and AusAID (ibid). NCHAD receives funding from the Global Fund, DFID and ADB, and is well financed the coming years (personal communication, Phom Penh 2005).

In 2001 there were 212 international NGOs in Vietnam, but only 22 were working on HIV/AIDS issues (Reid and Costigan 2002: 229). Today there are at least some 50 NGOs, international organisations and agencies, and bilateral donors active in the field (PATH 13 December 2004), and there is much money in the field (50 million USD today compared with 5 million USD three years ago). Vietnam is the only country in Asia that is on President George W. Bush's list for HIV/AIDS funding (PEPFAR). A growing number of NGOs are active in the field, and several people I talked to found that problematic because some NGOs have not enough experience (personal communication Hanoi March 2005).

In Laos there were 70 international NGOs in 2001 but only few directly working with HIV/AIDS activities. There are no national NGOs in Laos (Reid and Costigan 2002: 123), and the activities are coordinated by NCCA. Active organisations are PSI, Care International, FHI, Burnet Institute, Australian Red Cross, UNICEF and JICA, NCCA, and Lao Youth Union (personal communication Vientiane March 2005).

As noted many of the NGOs and donor agencies are active in more than one of the countries facilitating the spread of ideas and polices. The countries are also increasingly well funded in the field of HIV/AIDS—not the least compared to other health related areas. There are coordination efforts such as the "three ones" principle aiming at achieving the most effective and efficient use of resources and quick responses. The three ones stand for: one

HIV/AIDS Action Framework for coordinating the work of all partners, one National AIDS Coordinating Authority with multi-sectoral mandate, and one country-level monitoring and evaluation system (http://www.unaids.org/en/Coordination/Initiatives/three_ones.asp 18 July 2006). But there is still competition among the organisations making the policy process complicated because of the large number of actors and the fact that they have different working methods and agendas. Also, donors give mixed messages on how to structure the work and they have different incentive structures. In other words, the recipient countries have to deal with multiple ways of planning, implementing and assessing projects, programmes and strategies. Some actors are involved in the formulation of policy, others in implementing, and some in both stages, depending on the level of aid dependency and the role of external advisors. Also, criticism about the efficiency of the three ones in an Asian context has been forwarded. A survey by UNAIDS shows that while 80 percent of the countries had national AIDS authorities with a mandate to coordinate, only 41 percent had authority to allocate resources. This, plus a lack of expertise in specific areas leave the AIDS authorities hostage to political considerations (Godwin *et al.* 2006).

The role of the state

The state has by tradition been responsible for the health sector, and to a large extent HIV/AIDS still belong to this sector, even if governments are aiming at multi-sectoral approaches. However, the state has always been relatively weak in the health sector, Southeast Asia being no exception (and it should be remembered that the states in Burma/Myanmar, Cambodia and Laos are weak in the first place). The last few years' privatisation trend in Southeast Asia, together with attempts to improve the finances of the Ministry of Health, has led to an increase in private practices and out-of-pocket payments, thus reducing the role of the government as a health provider. For instance, in Burma/Myanmar and Vietnam privately financed and provided care is three to four times as large as spending on public services (in expenditure terms). At the same time the private health provision is barely recognised in legislation and regulation—and in the cases there are regulations it is not sure they are followed and implemented, as enforcement capacity is low (WHO 2000: 120-121). Because donors often cooperate with the government, the private sector does not receive very much funding, creating a skewed picture of the health care situation. In Vietnam, for example, many people living with HIV/AIDS prefer to go to private providers in order to avoid stigma, as most of the public facilities do not respect confidentiality. But the private sector does not have

enough or good equipment for example for testing (personal communication Hanoi March 2005). The problem with the neglect of the private sector is that decisions are made excluding a large part of the actual health sector.

The increase of funding is substantial,[11] but at the same time there are problems with the limited absorptive capacity—both for recipient NGOs and governments. Lately governments have increasingly been used as intermediaries to fund civil society organisation, which places even more pressure on distribution and accountancy of funds. This may, in turn, lead to more imported solutions on behalf of local responses (Halmshaw and Hawkins 2004). Another problem is that NGOs contribute to the brain drain from the public sector by attracting qualified staff from the governments (cf. Hall and Midgley 2004: 17; personal communication with the director of NAA, Phnom Penh March 2005). Also, the political and financial fatigue of aid donors and Northern governments can be noticed. For example, the Global Fund has struggled with severe financial constraints despite initial strong political support from the international community (Archibugi & Bizzari 2005: 38-39).

In the World Health Report 2000, the concept of stewardship was introduced. The idea is that the key role of the government should be oversight and trusteeship, and to "row less and steer more" (WHO 2000: 119). But the problem is that many governments do not recognise individuals and organisations outside the Ministry of Health, even if they actually play an important role. One should also remember that in authoritarian states civil society and NGOs are often treated with suspicion. At the same time grass-roots participation and civil society is not the answer to everything. Communities often are seen as "a nexus for implementation of currently popular beliefs in 'empowerment', stake-holding, and civil society which all too often are the human faces of technical fixes for many of today's problems of poverty and exclusion" (Barnett and Whiteside 2002: 194). Women may suffer from discrimination in the community, as the community may be a focus of conservatism, prejudice, stigma and active exclusion (ibid: 195). It might well be that civil society is conservative and the government progressive (see Boku and Whiteside 2004: 152). Many NGOs have been criticised for lack of accountability, lack of coherence and dependence on donors and sometimes also for acting in self-interest rather than for the good of their target groups (see e.g. Boussard 2003). Decentralisation is a way to get decision-making closer to the ground, but obviously not without problems

[11] In 2001 the funding was 1.6 billion USD globally and in 2005 8.3 billion USD. The estimated need in 2008 is 20 billion USD annually (WHO, press release 30 May 2006).

(Hall and Midgley 2004: 14). But the role of NGOs should not be underestimated. In net transfer terms, NGOs contribute with more resources than the World Bank (Hall and Midgley 2004: 15).

Donors promote "good governance"[12] as the remedy to the reduction of HIV infection rates. This is based on a notion that a certain kind of governance is better than "traditional governance" with the state as the main actor in the policy process. I would argue that although it might be the case in general, it could only be proved empirically. For example, the model with strong leadership, the full involvement of civil society, decentralised and democratic government organisation, multi-sectoral responses, which is promoted by most large international organisations and agencies as the best way to succeed in the combat of HIV/AIDS did not completely apply in the case of Uganda, where the centralised character of the regime ensured successful implementation—and Uganda has been considered to be a successful case (at least until recently). It has also been argued by James Putzel (2004) that the requirement to introduce a multi-sectoral approach and to establish stand-alone National AIDS Commissions in order to get international funding in some African cases (Uganda, Senegal and Malawi) has been counter productive insofar as they have contributed to the weakening of health sectors (and marginalising the Ministry of Health). To reorganise does not help if the problem is political priority. Solutions must be contextualised (also see Allen and Heald 2004).

In other words, there is an inherent tension between a strong public authority that can deliver systematic action and the need for democratic openness in order to halt the HIV/AIDS epidemic (Putzel 2004). To put it slightly differently, effectiveness stands against legitimacy. Effectiveness represents a top-down perspective where implementation, enforcement, monitoring, compliance are keywords. Legitimacy represents a bottom-up perspective where citizen and stakeholder participation, representation, accountability and transparency are emphasised (in other words, democratic dimensions). Here it is also important to discuss whose voice should be heard, and what are the power relations among the actors. "In terms of HIV/AIDS' impact on 'Voice' and marginalisation, it exacerbates and is in turn exacerbated by political and social exclusion" (Moran 2004: 10). Affected groups are especially women, migrant workers, sex workers and IDUs—groups that are already vulnerable.

[12] Good governance includes participation, accountability, equity, transparency, rule of law, effectiveness, responsiveness, efficiency, strategic vision and consensus orientation (UNDP 2002).

The question is then if the role of the state has changed. Jan Aart Scholte (2000: ch. 6) points out that the governance of today has retained the same bureaucratic character as the previous more statist governance. In other words, even if globalisation has challenged the sovereign state, the bureaucratic style of governance remains intact with "relatively permanent, formally organised, impersonally managed and hierarchically ordered decision-making procedures". At the same time, increasing globalisation has lead to "increased reliance on multilateral regulatory arrangements" (ibid: 133). Thus, the state still plays an important role, but governance has become more complex due to the many actors, agreements and regulations. So even if the state is providing less service due to privatisation, its role in policy development, coordination and regulation has increased (Bhatia and Mossialos 2004: 183). The question is, then, if the states have the capacity to live up to these new conditions.

Why on the political agenda now?

So how can we understand the fact that a growing number of organisations and agencies focus on HIV/AIDS right now? After all, HIV/AIDS has been a problem for more than 20 years. If we again use the Kingdon model a number of explanations can be suggested. If we look at the problem stream, there have been some changes. The number of infected has increased and probably more importantly, the epidemic has entered the general population in many parts of Asia. In other words, the epidemic is suddenly perceived more as a threat than previously (cf. Fidler 2004: 45). Moreover, HIV/AIDS has received a lot of attention through the MDGs, the Copenhagen consensus (www.copenhagen.consensus.com) and high profile donors such as Bill and Melinda Gates. Today HIV/AIDS is perceived as a societal problem rather than just as a health problem, and the more attention HIV/AIDS gets, the more funding is available. This attracts organisations and individuals willing to work in the field—for better and for worse. The impact of HIV/AIDS in Africa has become clear as well, and many worry that there will be a similar development in Asia. As the cost of treatment is increasing due to larger numbers of patients and there is no vaccine in sight, the situation appears even more precarious. Policy solutions have been available for a long time, but the political opportunity structure has changed lately. For example, the membership of Vietnam (1995), Laos, Burma/Myanmar (1997) and Cambodia (1999) in ASEAN has put pressure of greater involvement in international affairs. It was also in 1999, at a meeting in Chiang Rai, that the awareness of the need of a joint effort became clear to the leaders in the

region, and three years later the ASEAN Heads of State adopted a declaration on HIV/AIDS that stressed joint regional cooperation (UNDP 2002). Acknowledging this, pressure on national efforts to halt the epidemic increases. It should be noted though, that many of the organisations in the region were already in place, even if many of them worked with other issues before starting to focus on HIV/AIDS issues. The business sector is not yet very active in the field of HIV/AIDS in the five countries. This can be explained by the limited HIV transmission among productive people (Wågberg 2003: 7). However, UNAIDS has mobilised and empowered public-private partnerships involving the Thailand Business Coalition on AIDS (UNAIDS/04.35E).

In a similar way, one may wonder why the response to the epidemic has been so slow in Southeast Asia, both concerning policymaking at national and regional levels, considering that the first HIV cases were identified in the 1980s and early 1990s. One explanation is the relatively slow movement of the epidemic. The impact of HIV/AIDS has only gradually become clear, and there is no sense of costs yet (Barnett and Whiteside 2002: 300). The effects are long-term, and at present primarily "out-groups" and poor countries and poor people are the most affected. HIV/AIDS policymaking is nothing like the snap policy during the Asian financial crisis (see e.g. Barnett and Whiteside 2002: 291). Even at the global level the fight against the virus has been slow. For example, at the creation of UNAIDS in 1996 the idea was to include social and economic aspects of the epidemic in the work plan. However, for a long time the main focus of UNAIDS—and the national and regional programmes—was on clinical-medical and behavioural levels (Barnett and Whiteside 2002: 73) despite the fact that clinical medicine has only marginal effects on people's long-term health. Reduction of poverty, for example, is more efficient, as are clean water, access to food, sanitation, shelter education and preventative care (Barnett and Whiteside 2002: 27). This has been recognised lately in poverty reduction strategies and the adoption of MDGs together with issues such as governance, gender and human rights.

There have been substantial changes in the field of HIV/AIDS insofar as that there is more funding available and more organisations that focus on HIV/AIDS related issues. The collaboration patterns are increasingly complex with different kind of actors as well as divergent ways of doing things—despite efforts to facilitate the work through better coordination. The state capacity to deal with an increasingly complex world varies among the five countries putting more strains on the poorer ones. What is clear though is that the less state capacity the more reliance on donors and other external

actors, which in turn affect how to fight the HIV/AIDS epidemic. Thus, the relationship between policymaking, the role of the state and new forms of health governance in the light of increasing globalisation is crucial in order to understand why the epidemic is tackled in the way it is.

PART FOUR: Concluding remarks

The aim with this paper is to make a preliminary analysis of the relationship between global, national and local strategies to combat HIV/AIDS in Southeast Asia in the light of the increasing globalisation. What kinds of strategies are being used to fight HIV/AIDS and what makes certain policies more successful than others? Are there any new actors and collaboration patterns and what is the state capacity to deal with HIV/AIDS issues? The point of departure was that the context of policymaking in the field of HIV/AIDS is changing and that this has effects for health governance and the role of the state.

So what are the conclusions thus far? In terms of strategies, there are both similarities and differences between the five countries depending on the stage of the epidemic and how the epidemic is perceived and treated. Even so, multi-sectoral approaches encompassing a wide rage of activities are preferred over an initial focus on the health sector alone. What constitutes a successful policy is more complicated and renders no clear answers. It is possible to identify measures that probably will be successful, like those implemented in Thailand and to some extent in Cambodia, but any activity and/or policy must be related to its context and structural or institutional factors such as the political, bureaucratic and health care systems when evaluating "success" in a specific context. Furthermore, context must also be problematised. Arguably, a functioning health care system and administration ease policy implementation merely for practical reasons. Democratisation has facilitated the fight against the epidemic in Thailand and Cambodia by opening up the policy process, while the lack of democracy has hampered the efforts in Burma/Myanmar. But even if democracy is facilitating the combat against HIV/AIDS we do not know how much, or how little is necessary—as shown in the case of Uganda (also see Beyrer 1998 for the link between the HIV/AIDS epidemic in Southeast Asia and the wider issues of democracy and human rights). As mentioned above, there is a tension between a strong public authority that can deliver systematic action and the need for the democratic openness necessary for halting the epidemic. What is true though is that

without political will, and changes in social values and norms, the epidemic will continue to spread.

Undoubtedly global, regional and local strategies are inter-related through a large number of state and non-state actors and HIV/AIDS policies and agreements at different levels. Policymaking in one place or field affects policies in other places or fields, such as policies against illegal drug vs. policies to prevent HIV/AIDS transmission, inefficient HIV/AIDS policies in Burma/Myanmar vs. strong commitment in Thailand, and so on. The increasing attention on HIV/AIDS at the global level, notably through the MDGs and other initiatives, affect the work at regional and local levels—both in terms of norm-making and funding. The wishes of donor agencies colour the policymaking, even if many of the governments increasingly take ownership over the development. The context for policymaking is changing as the epidemic evolves, more actors enter the scene, and public and private are increasingly getting mixed. Globalisation processes may erode some of the state power, but at the same time more policies and regulations are needed demanding more state presence. Also, the implementation of policies and strategies are still in the realm of nations. Thus, the states still have an important role to play, but globalisation processes create new challenges and the role of the state must be problematised further. Finally, as has been shown throughout the paper, HIV/AIDS is an issue without boundaries, making policymaking a very complex issue. HIV/AIDS travels between countries, between groups with high-risk behaviour and the general population, between rich and poor, between urban and rural areas, from local to the global level, and affects medical, socio-economic, cultural and political spheres, which supports the idea of a broad approach to the subject.

This paper is work in progress, and must be treated as such. I have worked my way through the research questions, realising that more questions have arisen than have been answered. The theoretical framework has helped me to identify and problematise HIV/AIDS strategies and actors in the field of HIV/AIDS in Southeast Asia, providing me with a background for further studies. It has also helped me to conclude that the next step will be to elaborate on governance issues—both empirically and theoretically. It is important to incorporate a governance perspective into the policy approach, as this to a large extent is lacking in academic writings (cf. Jones 2005: 421). Quite a lot has been written about successful HIV/AIDS policies and about implementation difficulties, but we do not know enough about the role of governance in the fight against the epidemic. This, in turn, warrants further research.

References

Agence France Presse (2006) "Vietnam highlands face drug abuse, HIV threats: officials." Hanoi August 22.

Ainworth, M., C. Beyrer, A. Soucat (2003) "AIDS and public policy: the lessons and challenges of 'success' in Thailand." *Health Policy*, Vol. 64, pp. 13-37.

Allen, Tim (2004) "Introduction: Why Don't HIV/AIDS Policies Work?" *Journal of International Development*, 16: 1123-1127.

Allen, Tim and Suzette Heald (2004) "HIV/AIDS Policy in Africa: What Has Worked in Uganda and What Has Failed in Botswana?" *Journal of International Development*, 16: 1141-1154.

Altman, D. (2003) "Understanding HIV/AIDS as a Global Security Issue", in K. Lee, (ed) *Health Impacts of Globalization. Toward Global Governance.* Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.

Archibugi, Danielle & Kim Bizzari (2005) "The Global Governance of Communicable Disease: The Case for Vaccine R&D". *Law & Policy*, Vol.27, No. 1, pp. 33-51.

AusAID and UNDP (2004) *Report of the Study on the Organization System of National AIDS Programme in Vietnam*. Ha Noi: Project VIE/98/006.

Bhatia, Mrigesh and Mossialos, Elias (2004) Health Systems in Developing Countries. In Hall, Anthony and James Midgley. *Social Policy for Development.* London, Thousand Oaks, New Delhi: Sage Publications.

Barnett, Tony and Alan Whiteside (2002) *AIDS in the Twenty-First Century. Disease and Globalization.* Houndsmills, Basingstoke, Hampshire: Palgrave Macmillan.

Bexell, Magdalena (2005) *Exploring Responsibility. Public and Private in Human Rights Protection.* Lund: Department of Political Science (doctoral thesis).

Blanc, Marie-Eve (2004) 'An emerging civil society? Local associations working on HIV/AIDS'. In D. McCargo (ed.), *Rethinking Vietnam*. London and New York: RoutledgeCurzon.

Bloom, David E., Ajal Mahal, Larry Rosenberg, Jaypee Sevilla, David Steven, Mark Weston (2004) *Asia's Economies and the Challenge of AIDS*. Asian Development Bank. April.

Beyrer, C. (1998) *War in the Blood: Sex, Politics and AIDS in Southeast Asia.* London and New York: Zed Books; Bangkok: White Lotus.

Bourdier, Frédéric (2006) "Policies and politics underlying the path for universal access to treatment against AIDS in Cambodia". *Working Paper No 18.* Lund: Centre for East and Southeast Asian Studies. (www.ace.lu.se)

Boussard, Caroline (2003) *Crafting Democracy. Civil Society in Post-Transition Honduras.* Lund: Department of Political Science (doctoral thesis).

Brugha, R. and A. Zwi (2002) "Global approaches to private sector provision: where is the evidence?" in K. Lee, K. Buse, S. Fustukian (eds) *Health Policy in a Globalising World*. Cambridge: Cambridge University Press.

Buse, Kent (2004) "Governing Public-Private Infectious Disease partnerships". *Brown Journal of World Affairs*, Vol. X, Issues 2, pp. 225-242.

Chataway, Joanna, and Smith, James (2005) "The International AIDS Vaccine Initiative (IAVI): Is It Getting New Science and Technology to the World's Neglected Majority?" *World Development*, Vol. 34, No. 1, pp. 16-30.

Curtis, Donald (2004) "Looking for Strengths in Response to AIDS: Individual, Group and Public Authority Roles in Strategy". *Public Administration and Development,* 24: 51-59.

Far Eastern Economic Review (2003). "UN Gives China Low Grade on AIDS". Jan. 9.

Feingold, D. A. (2000) "The Hell of Good Intentions: Some Preliminary Thoughts on Opium in the Political Ecology of the Trade of Girls and Women", in G. Evans et al. *Where China Meets Southeast Asia*. Copenhagen: NIAS; Singapore: ISEAS.

Fidler, David P. (2004) SARS, *Governance and the Globalization of Disease.* Houndmills, Basingstoke, New York: Palgrave Macmillan.

Gilbert T. and L. Gilbert (2004) "Globalisation and local power: influences on health matters in South Africa". *Health Policy*, Vol. 76, pp. 245-255.

Godwin, Peter, O'Farrell, Nigel, Fylkesnes, Knut, Misra, Sujaya (2006) "Perspective: Five Myths about the HIV Epidemic in Asia" (I, II). *PloS Med* 3 (10): e426 (net version 3 October).

Goodwin, Robin et al. (2003) "Social representation of HIV/AIDS in Central and Eastern Europe". *Social Science and Medicine*, Vol. 56, pp. 1373-1384.

Gordenker, L., R. A. Coate, C. Jönsson, P. Söderholm (1997) *International Cooperation in Response to AIDS*. London and New York: Pinter.

Haas, P. M. (1992) "Introduction: Epistemic Communities and international policy coordination", *International Organization* 46, 1: 1-35.

Hall, Anthony and James Midgley (2004) *Social Policy for Development*. London, Thousand Oaks, New Delhi: Sage Publications.

Halmshaw, Caroline and Kate Hawkins (2004) "Capitalising on Global HIV/AIDS Funding: The Challenge for Civil Society and Government". *Reproductive Health Matters*, 12 (24): 35-41.

Halperin Daniel T. and Helen Epstein (2004) "Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention". *The Lancet*, Vol. 364, pp. 4-6.

Harmer, Andrew (2005) *Global Health Partnership as New Players in the Global Arena: An International Relation Perspective*. Antwerp: Report prepared for the Department of Public Health, Institute of Tropical Medicine.

Hill, Michael and Peter Hupe (2002) *Implementing Public Policy*. London: Sage Publication.

Howlett, Michael and M. Ramesh (2003) *Studying Public Policy. Policy Cycles and Policy Subsystems.* Oxford: Oxford University Press.

ICG, international crisis group. *Myanmar: Update on HIV/AIDS Policy*. Yangon/Brussels, 16 December 2004.

James, Helen (2005) *Governance and Civil Society in Myanmar. Education, health, and environment.* London and New York: RoutledgeCurzon.

Jones, Persi S. (2005) "A Test of Governance": rights-based struggles and the politics of HIV/AIDS policy in South Africa. *Political Geography*, 24: 419-447.

Jönsson, Christer and Peter Söderholm (1995) "IGO-NGO relations and HIV/AIDS: innovation or stalemate?" *Third World Quarterly*, Vol. 16, No. 3, pp. 459-476.

Jönsson, Kristina (2002) *Translating Foreign Ideas into Domestic Practices: Pharmaceutical Policies in Laos and Vietnam.* Lund: Department of Political Science (doctoral thesis).

Jönsson, Kristina (forthcoming) "Gendered Inequalities: HIV/AIDS in Southeast Asia". In Rydstrøm (eds) *Gendered Inequalities in Asia: Configuring, Contesting, and Recognizing Women and Men*. Copenhagen: NIAS.

Jørgensen, Bent (2005) "Democracy among the Grassroots: Local Responses to Democratic Reforms in Vietnam". In: Francis Loh Kok Wah and J. Öjendal (eds) *Southeast Asian Responses to Globalization*. Copenhagen: NIAS Press.

Kallings, Lars O. (2005) *Den yttersta plågan*. Boken om AIDS. Stockholm: Norstedts förlag.

Kermani, F. and P. Bonacossa (2003) "Patent issues and future trends in drug development". *Journal of Commercial Biotechnology*, Vol. 9, No. 4, ABI/INFORM Global, pp. 332-338.

Khuat Thu Hong, Nguyne Thi Van Anh and Jessica Ogden (2004) *Understanding HIV and AIDS-related Stigma and Discrimination in Vietnam.* International Center for Research on Women (ICRW).

Kingdon, John W (1995) *Agendas, Alternatives, and Public Policies*. New York: Harper Collins College Publishers. 2nd ed.

Kinnvall, Catarina and Kristina Jönsson (2002) Globalization and Democratization in Asia. *The Construction of Identity*. London and New York: Routledge.

Lijphart, A. (1975) The Comparable-Cases Strategy in Comparative Research. *Comparativ Political Studies*, Vol. 8, No. 2, pp. 158-177.

Lee, K and R. Dodgson (2000) "Globalization and Cholera: Implications for Global Governance", *Global Governance*, 6: 213-236.

Lee K, K. Buse, S. Fustukian (eds) (2002) *Health Policy in a Globalising World*. Cambridge: Cambridge University Press.

Lee, K. ed. (2003) *Health Impacts of Globalization. Toward Global Governance*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.

Lee, K. and A. Zwi (2003) "A Global Political Economy Approach to AIDS: Ideology, Interests and Implications", in K. Lee, ed. (2003) *Health Impacts of Globalization. Towards Global Governance.* Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.

Lee-Nah Hsu (2004) *Building Dynamic Democratic Governance and HIV-Resilient Societies*. UNAIDS/UNDP.

Mensch, Barbara S., Clark, Wesley H. and Dang Ngyuen Anh (2002) *Premarital Sex in Vietnam: Is the Currents Concern with Adolescent Reproductive Health Warranted?* New York: Population Council. Working Paper No. 163.

Ministry of Health/NCHADS (2002) *Report on HIV Sentinel Surveillance in Cambodia.*

Moran, Dominique (2004) "Symposium on HIV/AIDS, Governance. Guest Editors Preface". *Public Administration and Development*, Vol. 24, pp. 7-18.

Moran, Dominique (2004) "HIV/AIDS, Governance and Development: The Public Administration Factor". *Public Administration and Development*, Vol. 24, pp. 5-6.

Mutebi, Alex M. (2005) "Muddling Through" Past Legacies. Myanmar's Civil Bureaucracy and the Need for Reform. In Kyaw Yin Hlaing, Robert H. Taylor and Tin Maung Maung Than (eds) *Myanmar. Beyond Politics to Social Imperatives.* Singapore: Institute of Southeast Asian Studies.

Nicholson-Crotty, Jill and Sean Nicholson-Crotty (2004) "Social Construction and Policy Implementation: Inmate Health as Public Health Issue." *Social Science Quarterly*, Vol. 85, No. 2, pp 240-256).

Paphassarang, Chanthakhath, K. Philavobg, B Boupha and E Blas (2002) "Equity, privatization and cost recovery in urban health care: the case of Lao PDR". *Health Policy and Planning*, 17 (suppl 1): 72-84.

Parkhurst, Justin O. and Lousiana Lush (2004) "The political environment of HIV: lessons from a comparison of Uganda and South Africa." *Social Science and Medicine,* 59: 1913-1924.

Patterson, D. and L. London (2002) "International law, human rights and HIV/AIDS". *Bulletin of the World Health Organization*, 80 (12): 964-969.

Perks, Carol, Michael J Toole & Khamla Phouthonsy (2005) "District health programmes ahs health-sector reform: case study in the Lao People's Democratic Republic", *Bulletin of the World Health Organization*, 84 (2): 132-138.

Piot, P. and A. M. C. Seck (2001) "International response to the HIV/AIDS epidemic: planning for success". *Bulletin of the World Health Organization*, 79 (12): 1106-1112.

Poku, Nana K. (2002) "Global Pandemics: HIV/AIDS". In: Held, D. and McGrew A. (eds*) Governing Globalization. Power, Authority and Global Governance*. Great Britain: Polity Press in association with Blackwell Publishing Ltd.

Poku, Nana K. and Alan Whiteside, eds (2004) *The Political Economy of AIDS in Africa*. England: Ashgate.

Poore, P. (2004) "The Global Fund to fight Aids, Tuberculosis and Malaria (GFATM)". *Health Policy and Planning*, 19 (1), pp. 52-53.

Putzel, James (2004) "The Politics of Action on AIDS: A Case Study of Uganda". *Public Administration and Development*, 24, pp. 19-30.

Putzel, James (2004) "The Global Fight Against AIDS: How Adequate Are the National Commissions?" *Journal of International Development*, 16: 1129-1140.

Regional Outlook Southeast Asia 2006-2007 (2006) Singapore: Institute of Southeast Asian Studies (ISEAS).

Reid, Gary and Genevieve Costigan (2002) *Revisiting 'The Hidden Epidemic'. A Situation Assessment of Drug Use in Asia in the context of HIV/AIDS.* Australia: The Centre for Harm Reduction, The Burnet Institute.

Sabatier, Paul A. and Hank C. Jenkins-Smith (eds) (1993) *Policy change and learning: An advocacy coalition approach.* Boulder: Westview.

Safman, Rachel M. (2005) "Assessing the Impact of HIV and Other Health Issues on Myanmar's Development". In: Kyaw Yin Hlaing et al. (eds) *Myanmar. Beyond Politics to Societal Imperatives*. Singapore: Institute for Southeast Asian Studies.

Schairer-Vertannes, Rachel (2001) "The Politics of Human Rights: How the World Has Failed Burma". *Asia-Pacific Journal of Human Rights and the Law,* Vol. 2, No. 1, pp. 77-118.

Scholte, Jan Aart (2000) *Globalization, a critical introduction*. Houndmills, Basingstoke, Hampshire: Palgrave.

Sell, S. K. and A. Prakash (2004) "Using Ideas Strategically: The Contest Between Business and NGO Networks in Intellectual Property Rights". *International Studies Quarterly*, Vol.48, pp. 143-175.

Shadlen, Kenneth C. (2004) "Challenges to Treatment: The Price-Infrastructure Trap and Access to HIV/AIDS Drugs". *Journal of International Development*, 16: 1169-1180.

Shah Paung, Irrawaddy.org, 11 November 2005.

Söderholm, P. (1997) *Global Governance of AIDS. Partnership with Civil Society.* Lund: Lund University Press.

Templer, Robert (1998) *Shadows and Wind. A View of Modern Vietnam.* Great Britain: Little, Brown and Company.

Tepper, Steven J. (2004) "Setting Agendas and Designing Alternatives: Policymaking and the Strategic Role of Meetings". *Review of Policy Research*, Vol. 21, No. 4, pp. 523-542.

UN (2005) *Population, Development and HIV/AIDS with Particular Emphasis on Poverty*. New York: Department of Economic and Social Affairs, Population Division, United Nations (ST/ESA/SER.A/247).

UNAIDS (2004) UNAIDS at Country Level. Progress report. (UNAIDS/04.35E).

UNAIDS WHO AIDS Epidemic Update December 2005.

UNAIDS Press release 18 October 2004.

UNAIDS (2004) UNAIDS at Country Level. Progress Report (UNAIDS/04.35.E).

UNDP (2001) *The Impacts of Mapping Assessments on Population Movement and HIV Vulnerability in South East Asia.* South East Asia HIV and Development Programme.

UNDP (2002) *Introducing Governance into HIV/AIDS Programmes. People's Republic of China, Lao PDR and Viet Nam*. South East Asia HIV and Development Programme.

UNDP (2004) *Thailand's Response to HIV/AIDS: Progress and Challenges.* Thematic MDG Report.

Urwitz, Viveca and Anders Nyman (2002) *A follow up of the components for Swedish support in Burma/Myanmar, Cambodia, China (Yunnan Province), Laos and Vietnam.* Report on The Mekong Partnership and Beyond. Swedish International Development Cooperation Agency. Health Division Document 2002:5.

Walt, Gill (1994*) Health Policy. An Introduction to Process and Power.* UK: Zed Book Ltd.

Walters, Ian (2004) "Dutiful Daughters and Temporary Wives: Economic Dependency on Commercial Sex in Vietnam". In E. Micollier (ed.), *Sexual Cultures in East Asia. The Social Construction of Sexuality and Sexual Visits in Times of AIDS.* London: RoutledgeCurzon.

Webster, P. (2003) "HIV/AIDS explosion in Russia triggers research boom. Several studies now underway aim to offer solutions to the HIV/AIDS crisis for Russian policy makers". *The Lancet*, Vol. 361, Issues 9375, 21 June, pp. 2132-2133.

WHO (2006) *Important progress seen in tackling AIDS, but the epidemic continues to outpace response, says new comprehensive global AIDS update.* New York, 30 May (press release).

Willan, S. (2004) "Briefing: Recent Changes in the South African Government's HIV/AIDS Policy and Its Implementation". *African Affairs*, Vol. 103, pp. 109-117.

VNA (2006) *Vietnam provides guidance on implementing HIV/AIDS prevention law.* VNA news agency website, Hanoi, in English 19 August.

Wågberg, Erik (2003) *Mapping HIV Prevention in Southeast Asia*. Assessment of regional HIV prevention programmes and recommendations on strategic entry points for Sida. Mission Report to Sida/AIDS Secretariat. Lund: Sodeco.

Yin, R. K. (1986) *Case Study Research. Design and Methods*. Beverly Hills, London, New Dehli: Sage Publications.

WHO (2000*) The World Health Report 2000. Health Systems: Improving Performance.*

Zhang, Heather Xiaoquan (2004) "The Gathering Storm: AIDS Policy in China*". Journal of International Development*, 16: 1155-1168.

Öjendal, Joakim (2005) "A New Local State in Cambodia? Decentralization as a Political Commodity". In: Francis Loh Kok Wah and J. Öjendal (eds) *Southeast Asian Responses to Globalization*. Copenhagen: NIAS Press.

HIV/AIDS legal and policy documents

Cambodia

Law on the Prevention and Control of HIV/AIDS, No. NS/RKM/0702/015 (including Complementary Code of Conduct). National AIDS Authority, Kingdom of Cambodia.

Strategic Plan for HIV/AIDS and STI Prevention and care, 2004-2007. Ministry of Health, National Centre for HIV/AIDS, Dermatology and STD. Cambodia (September 2004).

NNA, National AIDS Authority, Kingdom of Cambodia (2001). A Situation and Response Analysis of the HIV/AIDS Epidemic in Cambodia. "Building and Better Understanding of the Situation and Response to HIV/AIDS in Cambodia", June.

UNAIDS (2004) Country Profile. An Overview of the HIV/AIDS/STI Situation & the National Response in Cambodia. 5th Edition December.

MoH/NCHADS (2004) Report on HIV Sentinel Surveillance in Cambodia 2002.

2001 Cambodia STI Prevalence Survey.

Cambodian Household Male Behavioural Surveillance Survey, IV 2000.

Laos

The National HIV/AIDS/STD Policy (2001), Ministry of Health, Lao PDR

The national Strategic Plan on HIV/AIDS/STD 2002-2005, Ministry of Health, Lao PDR

The National Action Plan on HIV/AIDS/STD 2002-2005, Ministry of Health, Lao PDR

Millennium Development Goals. Progress Report Lao PDR. January 2004. Government of the Lao PDR, United Nations.

Mid-term Review. UN Joint Plan of Action and Common Strategy on HIV/AIDS/STI 2002-2005. UN Theme Group on HIV/AIDS, Lao PDR 2003.

Striving to keep the prevalence low: Collaborative Response to HIV/AIDS in Lao PDR.

National HIV/AIDS/STI Programming Inventory. UN Theme Group on HIV/AIDS, Lao PDR. December 2003.

UNDP (2001) HIV Policy Formulation and Strategic Planning. For the Communication, Transportation, Post, Construction and Tourism sectors. Lao People's Democratic Republic.

Vietnam

The National Strategy on HIV/AIDS, Prevention and Control in Vietnam till 2010 with a vision to 2020 (The National Committee for AIDS, Drug and Prostitution Prevention and Control, Vietnam)

Decision No. 36/2004/QD-TTg, March 17, 2004 Approving the national strategy on HIV/AIDS prevention and control in Vietnam till 2010 with a vision to 2020.

The Government, No. 02/2003/CT-TTg, Directive of the Prime Minister on Strengthening HIV/AIDS prevention and control.

National Plan of Action for HIV/AIDS Prevention and Control, period 2001-2005.

N.25 (08-7-2000) Official Gazette. DECISION No. 61.2000/QD-TTg of June 5, 2000 on setting up the national Committee for AIDS, Drug and Prostitution Prevention and Fight.

The Government, Ref.:36/2004/QD-TTg DECISION of the Prime Minister approving the National Strategy on HIV/AIDS prevention and Control in Viet Nam till 2010 with a vision to 2020.

Websites

www.aseansec.org
www.copenhagen.consensus.com
www.freedomhouse.org
www.unaids.org
www.unandaids.org
www.undplao.org

Sida/SAREC has generously granted funding for field visits.